Inspire Foundation

Suicide prevention through online technologies

A submission to the Senate Community Affairs Committee Inquiry into Suicide in Australia

November 2009

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Committee Secretary
Senate Community Affairs References Committee
PO Box 6100
Parliament House
Canberra ACT 2600

November 2009

To *The Senate Community Affairs References Committee,*

RE: Submission to the Standing Committee's Inquiry into Suicide in Australia.

Thank you for your invitation to make this submission to the Standing Committee's *Inquiry into Suicide in Australia.* Inspire Foundation recognises the Government's overarching objective of shaping a government and sector response to reduce deaths by suicide and suicidal behavior. To this end, Inspire Foundation commends the Australian Government for taking the opportunity to investigate this critical issue.

The Inspire Foundation is a national non-profit organisation established in 1996 in response to the then escalating rates of youth suicide. Inspire's vision is to have a global impact on young people's mental health and wellbeing. With the mission to help millions of young people lead happier lives, Inspire serves young people aged 14-25 through two national, technology-based programs, Reach Out.com and Act Now.com.au.[1]

Young people are at the centre of all Inspire does – as partners in the development and delivery of all Inspire initiatives. We use innovative technology to reach young people and build trusted social brands that are part of their landscape. Inspire's work is evidence-based and underpinned by research and evaluation, conducted in partnership with leading academic institutions and research centres including the Brain and Mind Research Institute (BMRI) at the University of Sydney and Orygen Youth Health Research Centre, Centre for Youth Mental Health at the University of Melbourne.

The information and recommendations presented in this submission have been developed as a result of Inspire's extensive experience working with young people to develop effective technology-based programs aimed at improving young people's mental health and wellbeing. The research informing and experience of implementing Inspire's flagship program Reach Out means that the organisation has a unique contribution to make to this Inquiry in regard to youth suicide. Our connection with young people has enabled us to work together on this submission. You will hear their voices throughout this paper.

In addition to making this submission, Inspire Foundation has also worked in partnership with Suicide Prevention Australia, Lifeline Australia, OzHelp Foundation, The Mental Health Council of Australia and The Salvation Army to lead a sector response to the inquiry. For this reason, this submission will focus on the impact of suicide on young people and the role that internet and associated online technologies can play across the spectrum of intervention, from prevention to early intervention, treatment and promotion of positive mental health and wellbeing.

[1] Reach Out.com (www.reachout.com) provides information and support to young people going through tough times, and ActNow.com www.actnow.com.au) provides young people with opportunities and connections to find out more about their world and take action on the issues they care about.

This submission will address five of the inquiry's eight terms of reference as follows:

a) the personal, social and financial costs of suicide;

b) the accuracy of suicide reporting in Australia, factors that may impede accurate identification and recording of possible suicides (and the consequences of any under-reporting on understanding risk factors and providing services to the those at risk);

d) the effectiveness, to date, of public awareness programs and their relative success in providing information, encouraging help-seeking and enhancing public discussion of suicide;

e) the efficacy of suicide prevention training and support for front-line health and community workers providing services to people at risk;

f) the role of targeted programs and services that address particular circumstances of high risk groups.

We hope that you find the information and recommendations included in this submission of significant use to this Inquiry into this important issue. Please do not hesitate to contact me should you wish to discuss our submission further.

Kind regards,

Ms Kerry Graham
Chief Executive Officer
Inspire Foundation

Summary of Recommendations

Based on research and experience of programs to improve youth mental health and wellbeing, Inspire makes the following recommendations:

In relation to the development of a national policy response:

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

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

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

Recommendations - TOR a)

To build understanding and the evidence base measuring the true impact of suicide:

4. Investment to determine the quantification of the impact and cost of suicide and self-harm to the Australian community, including evidence-based research to assess the applicability of international costing models to the Australian context;

5. Assessment of various costing models and instruments (e.g. burden of disease) as a measure of outcomes and cost-effectiveness of specific suicide prevention strategies and interventions;

6. Evaluation of the ethical dimensions and strategic suitability of measuring economic costs of suicide relative to personal and social costs of suicide in Australia.

Recommendations - TOR b)

In relation to data and groups at increased risk of suicide:

7. That investment is made to enable the independent, transparent capture of data to inform decision-makers and the general community about our progress in addressing suicide. Key data elements would combine as part of a Suicide Accountability Framework to enable regular public reporting, contributing to increasing public understanding and diminishing stigma including:
    - rates of completed suicide among all populations; disaggregated by age, rural or remote location, disability and ethnicity;
    - links between self-harm and suicidal behaviour;
    - inclusion of sexual orientation and gender identity when collecting data for purposes such as coronial records and reports prepared by police to assist coroners, as well as in other health contexts (where appropriate and relevant).

8. Improve the national coronial database by inviting interdisciplinary and cross-agency collaboration, with a view to incorporating a broad range of mental health and socio-cultural factors which are currently not investigated;

   Improve consistency in coronial processes with regards to reporting on intent (including legislative clarity around the issue and consistency of terminology)- introducing graded coronial determinations of the likelihood of suicide and/or intent;

9. Commission research to elucidate what aspect of the recent decline in Australian youth suicide are due to real changes and which are due to artefact.

Recommendations - TOR f)

Targeted programs and services to reduce risk and increase protective factors for young people:

10. Encourage and actively support through social policies, young people's social connectedness through participation in existing networks such as service, sporting and social clubs, and online communities;

11. Increase individual protective factors through activities that encourage help-seeking behaviours, foster positive peer-relationships, improve self-esteem;

12. Investment in programs that support and raise awareness of youth suicide and groups at increased risk of suicide;

13. New and emerging technologies, including the internet and mobile phones, be seen as enablers of young people's mental health and wellbeing and an important setting in which mental health promotion can be undertaken;

14. Best available practice approaches be implemented to building resilience, help-seeking and the capacity for self-help;

15. That consumer participation be considered as essential in the design, development and delivery of programs.

Recommendations - TOR d)

In relation to mental health promotion:

Inspire Foundation acknowledges that an integral part of suicide prevention is mental health promotion, prevention and early intervention. An extension of this leads us recommend strategies and initiatives that address the social determinants of young people's mental health and wellbeing, in particular those which enhance protective factors.

16. New and innovative supports be implemented to support schools and local communities in delivering mental health promotion initiatives;

17. Develop a sustained national suicide awareness campaign that reaches the *whole of the community*, focuses on preventative care and promotes messages of hope, help-seeking, resilience, social inclusiveness and wellbeing among Australian individuals and communities;

18. Introduce programs that educate more widely on the misconceptions of suicide, seek to reduce stigma and strongly advocate for the expression of personal stories by those with experience of suicide (within best practice media guidelines) ;

19. Enhance the funding and resourcing capacity of the suicide prevention sector to raise awareness of suicide and promote help-seeking through programs and events that encourage public discussion;

20. Ensure programs related to the issue of suicide connect to other relevant social agenda issues, including substance abuse (drugs and alcohol);

21. Adequate funding be provided for community education and social marketing programs across the Australian community and for at-risk populations. Objectives should include eliminating stigma associated with mental illness, care seeking, and recovery from a suicide attempt. As recommended in our joint submission a national budget of $10m per annum for at least five years will be required to have a significant and sustained impact on community attitudes and behaviors;

22. Develop suicide prevention strategies that target mental illness as a whole and reduce the barriers to care for individuals with co-morbidity (e.g. substance misuse and mental health problems).

Recommendations - TOR f)

In relation to ICT in Mental health promotion and prevention

23. That the internet and associated technologies be recognised as a setting for the delivery of promotion and support services, particularly to young people.

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

Recommendations - TOR e)

In relation to workforce development:

25. New and emerging technologies, including the internet and mobile phones, 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;

26. Resources to build capacity of health care professionals to utilise ICT in their practice;

27. Increased resources for service providers to build capacity to deliver culturally sensitive and culturally specific responses (supporting mainstream suicide prevention initiatives) to individuals and communities at high risk of suicide and self-harm;

28. Increased support for community-based organisations to promote factors known to be protective for mental health and wellbeing (such as self-esteem, social connectedness and self-efficacy) to build community strength and the prevention of suicide and self-harm.

1. Overview of suicide and suicidal behavior amongst young Australians

Suicide is defined as the intentional taking of one's own life. Suicidal behavior is a broader term and includes self-inflicted and potentially injurious behaviors. Research shows that in an average year 12 classroom (thirty students), at least one young person will have attempted suicide.[2] In 2007, 245 young people aged 15-24 took their own lives; 187 young men, and 58 young women. While youth suicide rates have declined by 57% since 1997, suicide remains the leading causes of death among young people under the age of 30.[3]

Reporting and calculating suicide statistics is complex. The suicide literature shows a clear tension between two opposing views: those who believe that suicide is seriously under-reported, and that the data dilutes or even masks the extent and seriousness of the problem; and those who believe that despite under-reporting, enough is known to establish patterns, the dimensions of the phenomenon, risk factors, and therefore the basis for effective prevention program.[4]

The Australian Bureau of Statistics (ABS) mortality data is the main source of suicide statistics in Australia.[5] Earlier this year, the Australian Institute of Health and Welfare conducted a review of deaths which occurred in 2004.[6] They found that the lack of information from coroners regarding 'intent' meant that some cases which involved intentional self-harm were not classified as such and therefore not reported as suicide in ABS data. Taking these misclassified cases into account results in significantly larger numbers of deaths due to suicide and intentional self-harm than the numbers published in ABS mortality data.[7]

Reliable studies now put the number of suicides in Australia for 2007 at around 2500. It is generally accepted that the ABS suicide numbers are some 30-40% below the actual number of suicides. The reasons for this are complex but include stigma, religious beliefs and practices, the burden of proof for coroners, a lack of expert investigations and different reporting protocols across states and territories. Family and relatives also often fear that reporting a death as suicide will jeopardise life insurance or other forms of financial compensation.[8]

Self-harm is the leading cause of co-morbidity especially for young women. It is believed that for every suicide, there are between 10-20 attempted suicides. The Australian Institute of Health and Welfare intentional self-harm figures for young people aged 12-24 indicate there were 7,299 hospitalisations due to intentional self-harm— a rate of 197 per 100,000 young people. It is important to note however than self-harming behavior is not always indicative of suicidal ideation.

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[2] Sawyer, M., Arney, F., Baghurst, P., Clark, J., Graetz, B., Kosky, R., Nurcombe, B., Patton, G., Prior, M., Raphael, B., Rey, J., Whaites, L., and Zubrick, S. 2000, Mental Health of Young Australians, Commonwealth Department of Health and Aged Care, Canberra

[3] The overall suicide rates for young people aged 15 – 24 have decreased from 19.3 per 100,000 in 1997 to 8.3 per 100,000 in 2007, a 57% decrease. *Source:* Australian Bureau of Statistics (2009) ABS. Causes of Death. Publication 3303.0, Australian, Viewed 12/11/09 http://www.abs.gov.au/AUSSTATS/abs@.nsf/Lookup/970540FBE241B359CA257410000FBB30?opendocument

[4] Tatz, (2009) cited in Inspire Foundation, Lifeline, Suicide Prevention Australia, OzHelp Foundation, The Salvation Army and the Brain Mind Research Institute (2009) *Suicide is Preventable – A joint submission to the Inquiry into suicide.*

[5] These statistics are informed by information collected by the National Coroner's Information Service (NCIS) as well as the application of coding rules that form part of the International Classification of Diseases (ICD).

[6] Australian Institute of Health and Welfare (AIHW): Harrison JE, Pointer S and Elnour AA 2009.A review of suicide statistics in Australia. Injury research and statistics series no. 49.Cat. no. INJCAT 121. Adelaide: AIHW.

[7] Revised estimates are 3% higher than the ABS value when using similar criteria to the ABS, 11% higher when using these criteria and adding cases closed between the publication of *Causes of death, Australia, 2004* in March 2006 and the extraction date of the data used in this project, and 16% higher when including all deaths in NCIS identified as intention self-harm, when using a standard definition applied early in 2008.

[8] De Leo, D, Dudley, M, Aebersold, C, Mendoza, J, Barnes, M, Ranson, D and Harrison, J. *Achieving standardised reporting of suicide in Australia: rationale and program for change.* Accepted for publication, MJA, 2009

Between 1996–97 and 2005–06, the hospitalisation rate for intentional self-harm among young people increased by 43%, from 138 per 100,000 young people to 197. Rates of intentional self-harm hospitalisation were almost twice as high among Aboriginal and Torres Strait Islander young people compared with other young Australians in 2005–06 (332 hospitalisations per 100,000 young people aged 12–24 years compared with 188).

Although self-harm is not always intended to be fatal, the almost-two-fold increase in rates of intentional self-harm, the increase of female youth suicide in 2007, and the even higher levels of male youth suicide demonstrate an immediate need to effectively deliver appropriate mental health resources and services that reduce stigma and increase help-seeking in young people.

Suicide and self-harm both bring with them massive human, social and economic costs. Estimates indicate that each suicide impacts directly on the lives of at least six other people.[9] A completed suicide has a multiplier effect; impacting the lives of any number of individuals – from family to friends, colleagues, clinicians, first responders, coronial staff, volunteers of bereavement support services and other associates – who inevitably suffer intense and conflicted emotional distress in response to a death of this kind.[10]

Presently there are no reliable estimates on the cost of suicide and self-harm to the Australian community, however, the Californian Department of Mental Health (2008) estimated the combined cost of suicides and suicide attempts (a sub-set of self-harm) in that state in 2006 as $4.2 billion per year.[11] Inspire estimate of the financial cost to Australia as a result of suicide and suicidal behavior has been calculated at $17.5B (in 2007-08 dollars). This is approximately 1.3% of Gross Domestic Product (GDP), or $795 per person, per year. Even so, it is clear that the impact of suicide is far greater than can be measured using statistical means.

> *I don't really know where to begin or how to properly put into words the impact suicide or suicidality has on not only the person but their whole community. Throughout my life I've had quite a lot of people suffer from the impacts of suicide. My cousin committed suicide when I was 10, my boyfriends good friend committed suicide when I was 17 and a really good friend of mine who I had known since I was a baby committed suicide when I was 19. I've also had two friends attempt suicide and when I was 16 I did as well. The reasons why I attempted had nothing to do with knowing people who had tried or succeeded but I say this because I know what it's like to have been through it, to be taken to hospital and to receive treatment from a large variety of services.*
>
> **Female - age not disclosed**

Suicide touches every part of a young person's life and the associated experience of poor treatments and support leave a legacy that can impact on future help-seeking. Suicide is an event with multiple interacting, often complex, contributing factors. One of the most common and significant contributing factors is mental illness. The results of the ABS National Survey of Mental Health and Wellbeing shows that people with a mental illness are much more likely to have serious suicidal thoughts than other people (8.3% as compared to less than 1%). Other Australian research indicates that about 65% of those who die by suicide have symptoms consistent with major

[9] Corso, PS, Mercy, JA, Simon, TR, Finkelstein, EA and Miller, TR. *Medical costs and productivity losses due to interpersonal and self-directed violence in the US.* Am. J. Preventive Medicine, 32 (6): 474-482, 2007.
[10] Inspire Foundation, Lifeline, Suicide Prevention Australia, OzHelp Foundation, The Salvation Army and the Brain Mind Research Institute (2009) *Suicide is Preventable – A joint submission to the Inquiry into suicide.*
[11] Californian Department of Mental Health (2008) *California Strategic Plan on Suicide Prevention: every Californian is part of the solution.*

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

Inspire Foundation recommendations -TOR a)

To build understanding and the evidence base measuring the true impact of suicide

1. Investment to determine the quantification of the impact and cost of suicide and self-harm to the Australian community, including evidence-based research to assess the applicability of international costing models to the Australian context;

2. Assessment of various costing models and instruments (e.g. burden of disease) as a measure of outcomes and cost-effectiveness of specific suicide prevention strategies and interventions;

3. Evaluation of the ethical dimensions and strategic suitability of measuring economic costs of suicide relative to personal and social costs of suicide in Australia.

2. Mental health and wellbeing of Australian young people

The Australian Institute of Health and Welfare reports that adolescent depression is one of the most frequently reported mental health problems; with an estimated 481,600 Australians aged 18-24 currently living with an affective anxiety or substance abuse disorder. This represents approximately 26.5%; one in four young people in this age group.[12] Experiences of mental health problems such as depression can lead to other serious problems including substance abuse, social withdrawal, a breakdown in family and personal relationships and poor academic and work performance. Depression is also linked to substance abuse, eating disorders and implicated in many cases of youth suicide.[13]

Mental health problems, including depression, often have their onset in mid to late adolescence and early adulthood. More than 75% of lifetime cases of mental illness commence before the age of 25,[14] yet a large proportion of young people do not seek help from a professional.[15] Left untreated, mental health problems worsen, impacting significantly on the quality of a young person's life, including their relationships with family and friends and educational and vocational pursuits. Often young people self medicate with alcohol or drugs, finding themselves in a vicious cycle of depression, anxiety and substance use.[16] A specific focus on prevention and early intervention is necessary in order to reduce youth and adult mental health difficulties in the long term[17]

Suicide prevention literature highlights that mapping individual, social and contextual risk, as well as protective factors, can guide action at a community level, but emphasises that these cannot be used to directly assess whether an individual is at risk of suicide.[18]

> ***It's not really about the act of committing suicide but about all the reasons that lead up to that person considering that path.*** *The fact that people (especially kids and young people) have more and more pressure placed on them at a very young age, the fact that bullying is becoming even harsher, that to have mental health problems and to receive help is stigmatized and you are quite often judged and handled badly even by health care professionals themselves.*
>
> **Female - age not disclosed**

Young people are sensitive and aware of the challenges, and this quote clearly indentifies that more is needed in the area of de-stigmatisation, mental health promotion and help-seeking.

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[12] Australian Institute of Health and Welfare (AIHW) 2007, Young Australians: Their health and wellbeing, Australian Institute of Health and Welfare (AIHW), Canberra, Cat. no. PHE 87

[13] Rao, U., Daley, S.E., & Hammen, C. (2000). Relationship between depression and substance use disorders in adolescent women during the transition to adulthood. *Journal of the American Academy of Child and Adolescent Psychiatry, 39*,215–222.

[14] Kendall, P.C., & Kessler, R.C. (2002). The Impact of Childhood Psychopathology Interventions on Subsequent Substance Abuse: Policy Implications, Comments and Recommendations. *Journal of Consulting and Clinical Psychology, 70,* 1303-1306.

[15] Australian data indicates that only 29% of these young people contact a professional service of any type, results from the National Mental Health and Well Being survey (2007) indicating that only 13% of young men aged 16 to 24 seek help when experiencing a mental health difficulty during the formative adolescent and young adult years.

[16] Burns, J., Ellis, L., Mackenzie, A., & Stephens-Reicher, J. (2009). Reach Out Online Mental Health Promotion for Young People. *Counseling, Psychotherapy, and Health,* 5(1), The Use of Technology in Mental Health Special Issue, 171-186.

[17] Burns, J.M., Andrews, G., & Szabo, M. (2002). Depression in young people: What causes it and can we prevent it? *Medical Journal of Australia, 177*(7), S93-S96; McGorry P., Hickie, I.B., Yung, A.R., Pantelis, C., Jackson, H.J. (2006). Clinical staging of psychiatric disorders: a heuristic framework for choosing earlier safer and more effective interventions. *Australian and New Zealand Journal of Psychiatry*, *40*, 616-622.

[18] Department of Health and Ageing. (2007b). Living Is For Everyone (LIFE) Research and Evidence in Suicide Prevention. Canberra,

3. Groups at increased risk of suicide

3. 1 Same sex attracted + sex + gender diverse young people

Same sex attracted (SSA) and sex and gender diverse young people continue to experience higher rates of mental health problems than their cisgender heterosexual peers, and remain at greater risk of suicide and self-harm. Despite recent stabilisation of youth suicide rates more broadly SSA young people are 6 times more likely to attempt suicide and between 20-42% have attempted suicide compared to 7-13% of heterosexual young people.[19] The average age for SSA young people to attempt suicide is 16 years (often before they 'come out').[20] Bisexual identified young people have higher self-harm rates than exclusively homosexual identified young people (29.4% and 34.9% bisexual males & females respectively report self-harm).[21] While there is little Australian specific data available, emerging international research also suggests that sex and gender diverse young people are at even greater risk, reporting higher prevalence of suicidal ideation, attempted suicide and self-harm than both their cisgender heterosexual and same sex attracted peers.[22]

Studies highlight that sexuality and gender identity 'may play a distal or proximal role and interact with numerous other risk factors' leading to poorer mental health outcomes and increased risk of suicide and self-harm.[23] The physical and psychosocial development that takes place during adolescence is believed to compound issues surrounding sexual orientation and sex and gender identity, particularly in relation to developing a positive sense of self.[24]

The risk of suicide and self-harm among sexuality, sex and gender diverse communities is complex and is compounded by experiences of stigma, discrimination, and 'minority stress'. Sexual orientation, sex and gender identity alone do not necessarily elevate risk; rather, experiences of heterosexism, homophobia and transphobia are known to contribute to social isolation, poorer mental health outcomes, substance misuse, and other socio-cultural and economic problems and conditions, which in turn place these young people at greater risk of suicide and self-harm.

> *I have a few concerns when it comes to youth and mental health:*
> *1) Targeted programs/mental health services for gay, lesbian, bisexual, transgender, questioning (GLBT) young people. Rates of poor mental health, illness and suicide disproportionately affect young people who are gay. I can't think of anyone within my circle of glbt friends and acquaintances that HASN'T had depression, anxiety or another mental health issue. I know of too many young people who have taken their own lives due to issues around their sexuality and there are many for whom we will never know that it was a factor. A new friend told me during the week that his 16yo bf of two years recently committed suicide. Neither the person who died or my friend had/has support around them because it is not safe for them to be out. The issues/concerns that affect that are specifically glbt related.*
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> **Female - age 23**

[19] Dyson, S, Mitchell, A, Smith, A, Dowsett, G, Pitts, M, Hillier, L 2003, *Don't ask, don't tell. Report of the same-sex attracted youth suicide data collection project,* Australian Research Centre in Sex, Health & Society, Melbourne.
[20] Howard, J, Nicholas, J, Brown, G, Karaçanta, A 2002, 'Same-sex attracted youth and suicide', in Rowling, L, Martin, G, Walker, L (eds) *Mental Health Promotion in Young People,* McGraw Hill, Sydney.
[21] Nicholas, J, Howard, J 1998, 'Better dead than gay? Depression, suicide ideation and attempt among a sample of gay and straight-identified males aged 18 to 24', *Youth Studies Australia*, vol.17, no. 4, pp. 28-33.
[22] Sources: Di Ceglie, D 2000, 'Gender Identity Disorder in Young People', Advances in Psychiatric Treatment, vol. 6, pp. 458-466. Holman, CW, Goldberg, J 2006, 'Ethical, Legal and Psychosocial Issues in Care of transgender Adolescents', in Counseling and Mental Health Care of Transgender Adults and Loved Ones, Vancouver Coastal Health Unit, Transcend Transgender Support and Education Society, and the Canadian Rainbow Health Coalition, Vancouver; and Krieger, N 2003, 'Genders, sexes, and health: what are the connections-and why does it matter?', International Journal of Epidemiology, vol. 32, pp. 652-657.
[23] Howard, J, Nicholas, J, Brown, G, Karaçanta, A 2002, 'Same-sex attracted youth and suicide', in Rowling, L, Martin, G, Walker, L (eds) *Mental Health Promotion in Young People,* McGraw Hill, Sydney.
[24] Morrow, DF 2004, 'Social Work Practice with Gay, Lesbian, Bisexual and Transgender Adolescents', *Families in Society*, vol. 85, no. 1, pp.

This quote reminds us of the complex relationship between gender, sexuality and mental health. It is therefore important to acknowledge that estimating reliable suicide mortality statistics for these populations remains highly problematic as sexual orientation and gender identity, unlike other demographical characteristics, are not necessarily publicly known, or readily identifiable, through existing data collection methods (such as coronial records).[25] Consequently, there is a paucity of data on completed suicides among this cohort. Much of the literature therefore focuses on established indicators of suicide risk such as suicidal ideation and rates of attempted suicide and self-harm.

*** Inspire Foundation endorses the recommendations outlined in Suicide Prevention Australia (2009) position statement on *Suicide and self-harm amongst GBLT communities.***

3.2 Young men

Young men have the highest rates of suicide in Australia, almost three times that of aged matched females.[26] The need for a focus on males' mental health is compounded by the low level of help-seeking males engage in.[27] The national survey of mental health and wellbeing found that only 13% of males, compared with 31% of females in the age range of 16-24 seek professional help. Expressed another way females are 2.4 times more likely to attend a professional for help yet males are 3.1 times more likely to commit suicide. This disparity in help-seeking and suicide highlights the need to focus on males differently from their female counterparts with regards to mental health.

> *I feel that society is slowly becoming more aware about mental illness. I think organisations such as beyondblue and reachout are aiding in the fight to reduce the stigma surrounding mental illnesses. But I still feel that it's not talked about as open as it can be, especially around young males. Hopefully, this can change =)*
>
> **Male - age unknown**

Unfortunately Australia is not unique in its health status for males. When White, Fawkner and Holmes (2006) reviewed World Health Organization data from 44 countries they concluded that in general, epidemiological evidence suggests that men and women have different health challenges through the lifespan, with men consistently having the higher mortality across all countries surveyed from conception onwards.[28]

3.3 Young carers

Young carers are "children and young people who care or help care in a family affected by the illness, disability, mental health and/or drug or alcohol issues of one or more family members or friends". According to population statistics a substantial number of young people are carers in Australia, with 170,600 young carers aged up to 17 years and 348,000 young carers aged up to 25

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[25] Many researchers acknowledge that it is extremely difficult to estimate reliable suicide mortality rates for this population and that, consequently, sexuality, sex and gender diverse people may currently be under-represented in suicide death statistics due to methodological limitations surrounding the way in which data on sexuality and gender identity is collected. It is also believed that most suicide attempts by sexuality, sex and gender diverse 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 (Cole et al., 1997). Thus, sexual orientation and gender identity — unlike other demographical characteristics — are not always readily observable, and may not be known by family and friends at the time of death.

[26] *Source:* Australian Bureau of Statistics (2009) ABS. Causes of Death. Publication 3303.0, Australian, Viewed 12/11/09 http://www.abs.gov.au/AUSSTATS/abs@.nsf/Lookup/970540FBE241B359CA257410000FBB30?opendocument

[27] Australian Bureau of Statistics. (2007). *National Survey of Mental Health and Wellbeing: Summary of Results*. Viewed 18/11/09 http://www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/4326.02007?OpenDocument

[28] White, A., Fawkner, H. J., and Holmes, M. (2006). Is there a case for differential treatment of young men and women? *Medical Journal*

years.[29] The exact incidence of mental health problems amongst young carers in Australia is unknown, however it is clear that their mental health can be directly and indirectly affected in the short and long term due to impaired psychosocial development, low self-esteem and unresolved feelings of fear, worry, sadness, anger, resentment and guilt. These feelings may contribute to depression and emotional breakdown later in life.[30] Indeed, the Australian Unity Wellbeing Index identified that carers have the lowest collective wellbeing of any group studied, with an average rating on the depression scale that classifies as moderate depression.[31]

Studies from the United Kingdom also demonstrate that young carers report substantially higher rates of mental health and related problems, such as eating problems, difficulty in sleeping, and self harm.[32] Though, it is not clear whether the principal contributing factors to these disparities are explicitly related to their role as a young carer, or other mental health and socio-economic.[33]

Young carers living with a parent with a mental illness or alcohol or drug problem may also experience greater social isolation as a result of the stigma associated with their parent's mental illness or substance use, which in turn may compound the challenges of managing their parents' illness and inhibit social development. Additional responsibilities and demands related to caring may also: affect how much time they get to spend with friends, meet school/work commitments; place strain on family connectedness; require young carers to face potentially unsafe or risky situations; and negatively impact future outlook in life and challenges around transition to adulthood.

3.4 Alcohol and other drug abuse

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

According to research by Australian Institute of Health and Welfare in Statistics on Drug Use in Australia 2006, recent illicit drug use was most prevalent among people aged between 18 and 29 years. Almost one in three people (31%) in this age bracket had used at least one illicit drug and one in four had used cannabis in the previous 12 months. Approximately one in eight people aged 20–29 years recently used ecstasy, and around one in 10 had used meth/amphetamine in the last 12 months. Similar proportions of young people aged 18–19 years had recently used ecstasy and meth/amphetamine, each at 9%.

Approximately 80 per cent of people who complete suicide are over the legal drink-driving alcohol limit. Alcohol increases impulsivity, reduces complex thought/problem-solving ability, increases aggressive behavior, and reduces pain perception.[34] A Scottish report, "Lessons on Mental Health Care in Scotland", found that of 1,373 suicides studied, there was a history of alcohol misuse in 57 per cent of cases and drug abuse in 38 per cent.[35]

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[29] Australian Bureau of Statistics (2008) ABS Survey of Disability, Ageing and Carers 2003. Viewed 18/11/09 http://www.abs.gov.au/AUSSTATS/abs@.nsf/7f9c63244d12d1d0ca257090001cd4cc/4926cff764b65a25ca256bd000288447!OpenDocument

[30] Carers Australia (2001). *Young Carers Research Project*. Department of Family and Community Services, Canberra, September 2001 (http://www.carersaustralia.com.au/documents/young_carersfinal_report.pdf).

[31] Cummins, R, Hughes, J et al, October 2007. Report of Australian Unity Wellbeing Index Survey 17.1, The Wellbeing of Australians – Carer Health and Wellbeing, Deakin University, Australian Unity Limited and Carers Australia.

[32] Frank J., Tatum C., Tucker C. (1999). On Small Shoulders: Learning from the Experiences of Former Carers. London, Children's Society.

[33] Cree V.E. (2003). Worries and problems of young carers: issues for mental health. Child and Family Social Work, 8 (4), 301-309

[34] Inspire Foundation, Lifeline, Suicide Prevention Australia, OzHelp Foundation, The Salvation Army and the Brain Mind Research Institute (2009) *Suicide is Preventable – A joint submission to the Inquiry into suicide.*

[35] Eagles, Carson, Begg, Naji (2003)'Suicide prevention: a study of patients' views' in*The British Journal of Psychiatry* (2003) 182: 261-265

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

In addition, substance use prior to a suicide attempt can increase an individual's ability to engage in self-harming behaviour through a variety of mechanisms. For example, alcohol consumption can reduce cognitive function and decision-making capabilities, increase impulsivity, reduce pain perception and increase aggressive behaviours. Other legal and illegal substances can have similar and/or alternative effects that may precipitate suicidal behaviour. Those drugs that have the propensity to elicit psychotic episodes (e.g. methamphetamine, cannabis, heroin) may also increase the risk of suicidality, through delusional thoughts or hallucinations.[36]

Prevalence of risk factors, along with trends in suicide and attempted suicide rates, have been used to identify populations who are at greater risk of suicide[19]. Accordingly, Inspire's 2008-2012 strategic plan identifies four priority population groups considered at greater risk of developing mental health problems, and requiring targeted mental health promotion strategies. In addition to the groups acknowledged above, there are numerous other groups at elevated risk of experiencing mental health problems and engaging in suicidal behaviour including young people who are: Culturally and Linguistically Diverse, Indigenous, living with a disability or chronic illness or who come from a low socio economic background.[37]

Inspire Foundation recommendations - TOR b)

In relation to data and groups at increased risk of suicide:

1. That investment is made to enable the independent, transparent capture of data to inform decision-makers and the general community about our progress in addressing suicide. Key data elements would combine as part of a Suicide Accountability Framework to enable regular public reporting, contributing to increasing public understanding and diminishing stigma including:
    - rates of completed suicide among all populations; disaggregated by age, rural or remote location, disability and ethnicity;
    - links between self-harm and suicidal behaviour;
    - inclusion of sexual orientation and gender identity when collecting data for purposes such as coronial records and reports prepared by police to assist coroners, as well as in other health contexts (where appropriate and relevant).
2. Improve the national coronial database by inviting interdisciplinary and cross-agency collaboration, with a view to incorporating a broad range of mental health and socio-cultural factors which are currently not investigated;
3. Improve consistency in coronial processes with regards to reporting on intent (including legislative clarity around the issue and consistency of terminology) Introduce graded coronial determinations of the likelihood of suicide and/or intent;
4. Commission research to elucidate what aspects of the recent decline in Australian youth suicide are due to real changes and which are due to artefact.

[36] Inspire Foundation, Lifeline, Suicide Prevention Australia, OzHelp Foundation, The Salvation Army and the Brain Mind Research Institute (2009) *Suicide is Preventable – A joint submission to the Inquiry into suicide.*
[37] Burns, J., Collin, P., Blanchard. M., De-Freitas, N., & Lloyd, S. Disengaged Youth. Report for the Australian Research Alliance for

4. Risk and protective factors

Risk factors are personal characteristics or circumstances that may predispose an individual to suicidal behaviours or increase the likelihood of suicidality. Many risk factors have been identified and extensively researched. In addition, a range of protective factors have been identified – those characteristics or circumstances that prevent or reduce the likelihood of suicidality. Risk and protective factors may be related to the personal characteristics of the individual, events or incidents that have occurred during their life or their social environment. Often, risk and protective factors for suicide represent opposite ends of the same concept.

Risk factors have previously been defined as either ***non-modifiable*** or ***modifiable***. Non-modifiable risk factors are those that cannot be or are extremely difficult to change. These include issues such as genetic factors and predispositions, neurobiology, gender, age, gender identity/sexuality, ethnicity/culture, personality traits (e.g. impulsivity, neuroticism, hopelessness, aggression and problem-solving ability) and existing mental and/or physical illness. Modifiable risk factors are those they are able to be changed or those where an individual can change their perception or reaction towards a particular situation. Modifiable risk factors include issues such as social/geographic isolation, employment status, housing status, substance abuse and/or other addictive behaviours (e.g. gambling), past or current adverse life events (e.g. family violence/breakdown, physical, sexual, emotional abuse, neglect, financial problems), socio-economic status and broad environmental/political issues (e.g. natural disasters, global financial crisis, war). Although the classification of risk factors for suicide as either modifiable or non-modifiable is informative and assists in our understanding of suicide risk and suicide prevention, it is often difficult to use this definition in practice. Many "modifiable" risk factors, such as substance abuse or geographic location, can prove quite challenging to alter in a real-life setting and the modification of these issues may inadvertently introduce further risk factors for a particular individual.[38]

Research to date has overwhelmingly focused on identifying and understanding risk factors (those issues that increase the risk of suicidality). Studies focusing on protective factors and how they can be increased in vulnerable individuals to prevent suicidal behaviour have only occurred relatively recently. ***Resilience***, or the ability to cope with and even respond positively to potentially adverse life events, has been identified as a key protective factor for suicide and research into how it develops and how it can be increased across the population is growing.[39]

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

[38] Inspire Foundation, Lifeline, Suicide Prevention Australia, OzHelp Foundation, The Salvation Army and the Brain Mind Research Institute (2009) *Suicide is Preventable – A joint submission to the Inquiry into suicide.*

[39] Inspire Foundation, Lifeline, Suicide Prevention Australia, OzHelp Foundation, The Salvation Army and the Brain Mind Research Institute (2009) *Suicide is Preventable – A joint submission to the Inquiry into suicide.*

Recommendations -TOR f)

Development of targeted programs and services to reduce risk and increase protective factors for young people:

Inspire Foundation acknowledges that an integral part of suicide prevention is mental health promotion, prevention and early intervention. An extension of this leads us recommend strategies and initiatives that address the social determinants of young people's mental health and wellbeing, in particular those which enhance protective factors.

1. Encourage and actively support through social policies, young people's social connectedness through participation in existing networks such as service, sporting and social clubs, and online communities;

2. Increase individual protective factors through activities that encourage help-seeking behaviours, foster positive peer-relationships, improve self-esteem;

3. Investment in programs that support and raise awareness of youth suicide and groups at increased risk of suicide;

4. New and emerging technologies, including the internet and mobile phones, be seen as enablers of young people's mental health and wellbeing and an important setting in which mental health promotion can be undertaken;

5. Best available practice approaches be implemented to building resilience, help-seeking and the capacity for self-help.

6. That consumer participation be considered as essential in the design, development and delivery of programs.

5. Barriers to help-seeking and stigma

The evidence is clear that with early treatment, most people recover from a mental illness and are able to fully participate in the social and economic life of the community. Internationally, epidemiological studies suggest that while one in five young people experience mental health problems between 60 and 80% do not seek professional help.[40] When young people do seek help, it is most typically from informal, non-professional sources such as friends and family rather than professional sources such as a physician or mental health professional.[41] Many young people believe that they can handle emotional problems on their own and state concerns relating to confidentiality, a fear that no person or service could help, and the feeling that the problem was too personal to tell anyone, as reasons for not seeking help.[42]

Young people themselves tell us that there are several barriers that prevent young people from seeking help:

> *I 1 in 5 people in Australia are affected by mental health problems each year. IT'S A BIG ISSUE that I think needs to be addressed more and to help stop the stigma that is attached to mental health issues. When the wider community think of mental health, they think crazy people! Mental health isn't about that at all… the people affected by it could be you, me, your family, your friend. We need to make it so that it isn't such a big deal for people to ask for help with a problem no matter how big or small it is. It's not a 'bad' thing!*
>
> **Female – age not disclosed**

> *I've been affected by mental health and it's one the most disabling thing, and I've got a heart condition! The reason why I didn't go and get help? Embarrassment and not enough awareness on what I had...I dont want anyone else to go through what I did, it's not fair and the best thing (or perhaps the worst) is that people don't have to!*
>
> *Lets try and raise awareness and acceptance guys!!*
>
> **YP – age not disclosed**

Stigma, lack of understanding about mental health problems; issues relating to confidentiality and feeling embarrassed about what a professional might think; and physical constraints including a

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[40] Sources: Burns BJ, Costello EJ, et al. Children's mental health service use across service sectors. Health Affairs 1995;14:147-59; Leaf PJ, Cohen P, et al. Mental health service use in the community and schools: results from the four-community MECA Study. Methods for the epidemiology of child and adolescent mental disorders study. J Am Acad Child Adolesc Psychiatry 1996;35:889-97; Offer D, Howard KI, Schonert KA, Ostrov E. To whom do adolescents turn for help? Differences between disturbed and nondisturbed adolescents. J Am Acad Child Adolesc Psychiatry 1991;30:623-30; Rickwood DJ, Braithwaite VA. Social-psychological factors affecting help-seeking for emotional problems. Soc Sci Med 1994;39:563-72; Saunders SM, Resnick MD, Hoberman HM, Blum RW. Formal helpseeking behavior of adolescents identifying themselves as having mental health problems. J Am Acad Child Adolesc Psychiatry 1994;33:718-28; and Sawyer MG, Arney FM, Baghurst PA, Clark JJ, Graetz BW, Kosky RJ,et al. The mental health of young people in Australia: Key findings from the Child and Adolescent Component of the National Survey of Mental Health and Wellbeing. Aust NZ J Psychiatry 2001;35:806-14.

[41] Sources: Boldero J, Fallon B. Adolescent help-seeking: What do they get help for and from whom? J Adolescence 1995;18:193-209; Gould MS, Munfakh JL, Lubell K, Kleinman M, Parker S. Seeking help from the internet during adolescence. J Am Acad Child Adolesc Psychiatry 2002;41:1182-9; and 16. Jorm AF, Wright A. Beliefs of young people and their parents about the effectiveness of interventions for mental disorders. Aust NZ J Psychiatry 2007;41: 656-66.

[42] Sources: Dubow EF, Lovko KRJr, Kausch DF. Demographic differences in adolescents' health concerns and perceptions of helping agents. J Clin Child Psychol 1990;19:44-54; and Gould MS, Munfakh JL, Lubell K, Kleinman M, Parker S. Seeking help from the internet

lack of resources and geographical location of services are all significant barriers that young people experience.[43]

Stigma is a socially discrediting attitude or behaviour and individuals beholding these discredited attributes can become rejected from society. Of interest to health professionals are the additional constructs, self-stigma and perceived stigma. Self stigma refers to the negative attitudes and responses an individual has of themselves as a result of internalising broader stigmatizing attitudes in the community. Perceived stigma is the expectations and perceptions of the stigmatised attitudes and responses of others.[44]

Research highlights that young people can feel embarrassed about a mental health problem and would prefer others not to know about their concerns, which creates a clear help-seeking barrier.[45] Both self and perceived stigma have been found to predict and inhibit help-seeking behaviour.[46] Community strategies aimed at reducing societal stigma, combined with interventions to reduce self stigma and perceived stigma (Barney et al., 2006) together have the potential to improve help-seeking behaviour in young people.

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

Less than half of those who attempt suicide receive medical attention and many do not seek help or come to the attention of health care professionals.

> *Mental health is such an important area. 1 In 5 people are affected. As a young person who has suffered from mental health issues for nearly 5 years, I did not seek help straight away as there is so much stigma in todays society. I think that there is not enough being taught in schools and not as nearly enough services available or general support.*
>
> *However, within those 5 years there has been a dramatic increase of support and services available, but still not enough. Still there is not enough awareness in society and the chance of being isolated by friends, peers etc is still pretty high if you tell them that you are suffering a mental health problem.*
>
> **Female - age unknown**

[43] Campbell, A.T. (2006). Consent, competence, and confidentiality related to psychiatric conditions in adolescent medicine practice. *Adolescent Medicine Clinics, 17,* 25-47; Kapphahn, C., Morreale, M., Rickert, V. I., & Walker, L. (2006). Financing mental health services for adolescents: a background paper. *Journal of Adolesent Health, 39,* 318-327; Leaf, P.J., Cohen P. & et al. (1996). Mental health service use in the community and schools: results from the four community MECA Study. Methods for the Epidemiology of Child and Adolescent Mental Disorders Study. *Journal of American Academy of Child and Adolescent Psychiatry., 35,* 889-897.

[44] Barney, L. J., Griffiths, K. M., Jorm, A. F. & Christensen, H. (2006) Stigma about depression and its impact on help-seeking intentions. Australian and New Zealand Journal of Psychiatry, 40, 51 - 54.

[45] Sources: Jorm, A. F., Barney, L. J., Christensen, H., Highet, N. J., Kelly, C. M. & Kitchener, B. A. (2006) Research on mental health literacy; what we know and what we still neeed to know. *Australian and New Zealand Journal of Psychiatry,* 40**,** 3-5; and Wilson, C. J., Deane, F. P., Ciarrochi, J. & Rickwood, D. (2005) Measuring Help-Seeking Intentions: Properties of the General Help-Seeking Questionnaire. Canadian Journal of Counselling, 39, 15-28.

[46] Barney, L. J., Griffiths, K. M., Jorm, A. F. & Christensen, H. (2006) Stigma about depression and its impact on help-seeking intentions.

Factors influencing help-seeking include the severity of the injury, the availability, accessibility and quality of health care services and the fear of possible negative consequences. Other barriers that were identified include fear of being stigmatised, fear of hospitalisation, issues of trust and confidentiality, stigma and perceived loss of esteem.

In addition to cost, sensitive and locally accessible services, young people told Inspire that stigma and a lack of mental health literacy remains a major barrier to seeking professional help for depression and mental health issues. This indicates the need for alternative services salient to young people that will reduce these barriers and increase help-seeking.

> *This is SUCH an important issue, it affects so many people, and a lot of people suffer in silence. Our society tends to focus on things it can SEE, and while people are more than happy to rush to the doctor when something physical is wrong, its a different story all together when the problems are mental.*
>
> *This is why we need more awareness on this issue, from the government and from society as a whole, so people know that it is just as important as physical diseases and people can get the treatment and care they need.*
>
> **Female - age unknown**

> *When it comes down to it if you have been struggling for years and years and years and you have tried hospitals, medications and lots of different services and therapies but they don't work, they will not accept you, they are inter-state or overseas, you don't have the money, the waiting list is 6 months to two years, they don't take you seriously or whatever other reasons there is and you come to the realisation that you may very well have to live with this horrible disease because no one can help don't you think suicide may very well come to mind. So its about making sure that people never have to reach that point of contemplating their last resort.*
>
> **Female – age not disclosed**

Young people also suggested that schools could play a role in supporting mental health and wellbeing and promoting mental health literacy. Schools and teachers are ideally positioned to play a lead role in mental health promotion and prevention activities due to the nature of the interactions they have on a daily basis with young people.

> *If I could talk to Kevin Rudd face to face about anything it would have to be about what young youths are taught at school. There is so much mental illness, suicides, drug and alcohol issues! If they brought in a subject that was taught everyday and mandatory in all schools, based on building self-esteem, how to redirect thoughts in a positive way, taking responsibility for your life, how to make choices that are best for your own life and goal setting. These factors are such a big part of how we live our life. This could work, and would change the life of millions.....*
>
> **Female – age 36**

Research has demonstrated that a sense of connectedness or attachment to school is a key protective factor in reducing the risk of mental difficulties for young people. There is also increasing awareness that schools are often the first to identify child and adolescent mental health problems and can also be the first point of contact for parents with concerns about their children.

School-based resilience, competency and skill enhancement programs – activities and programs that are delivered in a school setting that aim to increase protective factors, such as resiliency, and encourage a culture of help-seeking (the Mind Matters resources are a good example of school-based resources and programs offered in Australia – see website for examples www.mindmatters.edu.au).

Inspire Foundation recommendations -TOR d)

In relation to mental health promotion:

1. New and innovative supports be implemented to support schools and local communities in delivering mental health promotion initiatives;

2. Develop a national suicide awareness campaign that reaches the *whole of the community*, focuses on preventative care and promotes messages of hope, help-seeking, resilience, social inclusiveness and wellbeing among Australian individuals and communities;

3. Introduce programs that educate more widely on the misconceptions of suicide, seek to reduce stigma and strongly advocate for the expression of personal stories by those with experience of suicide (within best practice media guidelines);

4. Enhance the funding and resourcing capacity of the suicide prevention sector to raise awareness of suicide and promote help-seeking through programs and events that encourage public discussion;

5. Ensure programs related to the issue of suicide connect to other relevant social agenda issues, including substance abuse (drugs and alcohol);

6. Adequate funding be provided for community education and social marketing programs across the Australian community and for at-risk populations. Objectives should include eliminating stigma associated with mental illness, care seeking, and recovery from a suicide attempt. As recommended in our joint submission a national budget of $10m per annum for at least five years will be required to have a significant and sustained impact on community attitudes and behaviors;[1]

7. Develop suicide prevention strategies that target mental illness as a whole and reduce the barriers to care for individuals with co-morbidity (e.g. substance misuse and mental health problems).

6. The role of ICT in mental health promotion and prevention

The internet and its associated technologies are a way of life for young people. In 2008, national surveys of internet use showed that 95% of 18 to 25 year olds are online, and after family and friends, it's where young people turn to for advice and support in difficult times.[47] With its unique ability to connect people to information and each other, the Internet offers opportunities to engage the 71% of young people experiencing mental health problems who are not currently seeking professional help.[48] Importantly, the Internet, mobile phone applications and social marketing enable health promotion and early intervention programs to be delivered at scale.

Given the rapid evolution of the internet, much of the 'knowledge' about its impact focuses on dangers to the individual epitomised by concerns that it acts as a catalyst for negative interactions such as bullying, suicide, sexual predation and anti-social behaviours such as internet addiction.[49] However, young people also report feeling empowered online, able to access immediate feedback and more confident in accessing and talking about sensitive topics[50]such as depression;[51]sexuality or sexually transmitted diseases [52] and physical activity and nutrition.[53] However, the tendency of such research is to focus on outcomes, in isolation from young people's everyday lives.

Increasing knowledge and understanding about health issues is important but perhaps the greatest contribution the internet can make to wellbeing will be to reduce the stigma associated with mental health difficulties, promote help-seeking in the offline world and build community and promote meaningful participation. [54] For example, research on the role of online support groups finds they can 'clearly provide essential social support for otherwise isolated adolescents',[55] offer the 'same assistance strategies as face-to-face' groups[56] and provide 'a supportive conversation or a referral to appropriate help resources'.[57] A study of an online self-harm discussion group reported it as 'having positive effects, with many respondents reducing the frequency and severity of their self-harming behaviour as a consequence of group membership'.[58]

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[47] Wyn, J., Cuervo, H., Woodman, D., and Stokes, H. 2005, Young people, wellbeing and communication technologies, VicHealth, Melbourne

[48] Sawyer, M.G., Sarris, A., Baghurst, P.A., et al. The prevalence of emotional and behavioural disorders and patterns of service utilsation in children and adolescents. Australian and New Zealand Journal of Psychiatry 2002;24(3):323-330.

[49] Sources: Mitchell, K. J., Ybarra, M. and Finkelhor, D. (2007) 'The relative importance of online victimization in understanding depression, delinquency, and substance use', *Child Maltreatment,* 12: 314-324; Tam, J, Tang, W. S. and Fernando, D.J., (2007) 'The internet and suicide: A double-edged tool', *European Journal of International Medicine*, 18: 453-455; and Ha, J. H., Kim, S. Y. Bae S. C. et al., (2007) 'Depression and Internet addiction in adolescents', *Psychopathology,* 40: 424-430.

[50] Gould, M. S., Munfakh, J. L. Lubell K. et al., (2002) 'Seeking help from the internet during adolescence', *Journal of American Academy of Child Adolescent Psychiatry*, 41: 1182-1189; and Nicholas, J., Oliver, K. and Lee, K. et al., (2004) 'Help-seeking behaviour on the Internet: An investigation among Australian adolescents', *Australian e-Journal for the Advancement of Mental Health*, 3: 1-8.

[51] Sources: Burns, J., Morey, C., Lagelée A., Mackenzie, A. and Nicholas, J. (2007) 'Reach Out Innovation in service delivery', *Medical Journal of Australia*, S31 – S34: 187; and Leach, L. S., Christensen, H., Griffiths K.M. et. al., (2007) 'Websites as a mode of delivering mental health information: perceptions from the Australian public', *Social Psychiatry and Psychiatric Epidemiology*, 42: 167-172

[52] Suzuki, L. K. and Calzo, J.P. (2004) 'The search for peer advice in cyberspace: An examination of online teen bulletin boards about health and sexuality', *Applied Developmental Psychology,* 25: 685-698

[53] Spittaels, H and De Bourdeaudhuij, I (2006) 'Implementation of an online tailored physical activity intervention for adults in Belgium', *Health Promotion International,* 21: 311-318.

[54] Sources: Berger, M., Wagner, T.H. and Baker, L.C. (2005) 'Internet use and stigmatized illness', *Social Science and Medicine,* 61: 1821-1827; Leach, L. S., Christensen, H., Griffiths K.M. et. al., (2007) 'Websites as a mode of delivering mental health information: perceptions from the Australian public', *Social Psychiatry and Psychiatric Epidemiology*, 42: 167-172; and Santor, D. A., Poulin, C. LeBlanc, J. C. et al., (2007) 'Online health promotion, early identification of difficulties, and help-seeking in young people', *Journal of American Academy of Child Adolescent Psychiatry,* 46: 50-59.

[55] Whitlock, J. L, Powers, J.L. and Eckenrode, J. (2006) 'The Virtual Cutting Edge: The Internet and Adolescent Self-Injury', *Developmental Psychology,* 42:1-11.

[56] Winzelberg, A., (1997) 'The analysis of an electronic support group for individuals witheating disorders', *Computers in Human Behavior,* 13: 393-407.

[57] Barak, A., (2007) 'Emotional support and suicide prevention through the Internet: A field project report', *Computers in Human Behaviour*, 23:971-984.

[58] Leung, L., (2007) 'Stressful life events, motives for Internet use, and social support among digital kids' *Cyberpsychology and Behaviour*, 10: 204-214.

Such innovative web-based initiatives demonstrate that ICT - rethought of as a setting in which 'devices, activities and social arrangements' are activated - can have a powerful impact on the wellbeing of young people. Reach Out (www.reachout.com.au) is an Australian initiative that utilises a website, podcasting, digital storytelling, community forums, an online gaming platform, SMS and social networking site campaigns to deliver information, reduce mental health stigma and promote help-seeking[59]. Online profiling, conducted in 2006, of 1432 Reach Out visitors (aged 16 – 25) shows that 75% said they would return to the site if going through "tough times" and 80% would refer it to a friend. When repeat visitors were asked if they had sought help after visiting Reach Out, 38% said they had spoken to a mental health professional.[60] Research that accounts for the complex interplay between individual behaviour, interpersonal relationships and the settings in which young people spend their time (school, streets, church groups) – including the internet – will provide a richer understanding of the impact of ICT on young people's wellbeing.

The Internet is accessible, anonymous, engaging and informative, providing a space where young people can feel empowered and confident to talk about sensitive issues. Our experience through both Reach Out and ActNow has reinforced that the online environment in an important setting in which to engage young people. The email below demonstrates just how valuable these services can be.

> **Email from young person to www.ReachOut.com – 3:43am**
>
> *hey guys,*
>
> *look just wanted to say thank-you so much that you gave up your time to make this site.*
>
> *I want you to know for what its worth you saved my life tonight i was very close to killing myself until i read your site and it is safe to say that it is the only thing that stopped me tonight. So i just want to thank everyone that has put there time and hard work into this site cause im sure that there has been many others like myself and i hope that u coninute with this site and hope that it keeps helping others. Thank-you for another chance at life. All the best wishes for the furture for you guys and once again thanks.*
>
> ***Female – age unknown***

Internet-based resources are acknowledged for their ability to engage and empower marginalised and traditionally 'hard to reach' groups via the transgression of geographical, logistical and even psychosocial barriers that may otherwise inhibit such groups from accessing offline health promotion programs or health care providers.[61] ICT therefore offers significant potential as a tool and setting for mental health promotion and suicide prevention for all young people, but particularly, young men, young carers, AOD and same sex attracted and sex and gender diverse young who face significant challenges in accessing information and support.

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[59] Burns, J., Morey, C., Lagelée A., Mackenzie, A. and Nicholas, J. (2007) 'Reach Out Innovation in service delivery', *Medical Journal of Australia*, S31 – S34: 187

[60] Burns, J., Morey, C., Lagelée A., Mackenzie, A. and Nicholas, J. (2007) 'Reach Out Innovation in service delivery', *Medical Journal of Australia*, S31 – S34: 187

[61] Sources: Alexander, J. (2002). Queer Webs: Representations of LGBT People and Communities on the World Wide Web. International Journal of Sexuality and Gender Studies, 7(2-3), 77-84; Burns, J., Morey, C., Lagelee, A., Mackenzie, A., & Nicholas, J. (2007). Reach Out Innovation in service delivery. Medical Journal of Australia, 187(7), S31-S34; Cline, R. J. W., & Haynes, K. M. (2001). Consumer health information seeking on the Internet: the state of the art. Health Education Research, 16(6), 671-692; Drabble, L., Keatley, J., & Marcelle, G. (2003). Progress and opportunities in Lesbian, Gay, Bisexual and Transgender Health Communications. Clinical Research and

Inspire Foundation recommendations -TOR f)

In relation to ICT in Mental health promotion and prevention

1. That the internet and associated technologies be recognised as a setting for the delivery of promotion and support services, particularly to young people.

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

7. Enhancing treatment and support to young people through technology

Research conducted by the Inspire Foundation - Bridging the Digital Divide - found that while information communication technology (ICT) is an integral part of the lives of a diverse range of young people, many youth service providers have limited capacity to use technology in their engagement with young people.[62]

While most service providers feel confident completing basic ICT tasks, many lack the knowledge, skills and confidence to provide support to young people using technology. They report not understanding the websites that young people engage with and have a poor understanding of the role technology plays in young people's lives. A further study, undertaken with health care professionals found that while those who care for our young people are beginning to recognise the significant potential of technology to impact young people's mental health and wellbeing, substantial investment in infrastructure is required to ensure that the sector can leverage evidence-based online interventions. Policies that foster innovative practice, while overcoming concerns regarding safety are urgently required to allow this potential to be realised.[63]

As information and communication technology plays a central role in the lives of young people, it follows that building capacity of health care professionals to utilise ICT in their practice could provide a powerful compliment to face to face interventions.

In the words of Ian Hickie, Executive Director of the Brain & Mind Research Institute:

> *"It's a matter of staying conversive enough to show we have an active interest in your world of technology like making friends on Facebook etc. Its not things we (professionals) immediately understand. It's not something readily produced for the professional market."*

Recognising the significant role technology plays in the lives of young people, Inspire Foundation's Reach Out Pro provides access and advice for health care professionals on a range of technologies and online resources that can be used to enhance the effectiveness of the psychosocial support and mental health care provided to young people.

Reach Out Pro encourages health care professionals to become acquainted with new technologies and their significance to young people and to integrate the use of technology into their practice to better meet the needs of young people and ultimately improve mental health outcomes.

Reach Out Pro is closely linked to ReachOut.com to help provide young people with access to an online community and trusted information and advice. The two main objectives of Reach Out Pro are to: (1) increase health care professionals' understanding of the role technology plays in the world of young people and how it allows them to express themselves and connect with their peers and (2) increase health care professionals' understanding of how Internet-based technology can be used to engage young people in improving their mental health and wellbeing.[64]

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[62] Blanchard, M., Metcalf, A., Burns, J. Marginalised young people's use of Information and Communication Technology, 'Bridging the Digital Divide' (report), Inspire Foundation and Orygen Youth Health, University of Melbourne.

[63] Blanchard, M. (2009) "Understanding the policy implications of using information communication technology to improve youth mental health," Emerging Health Policy Research Conference, Sydney, NSW, 19th August 2009.

[64] Reach Out Pro has two major components; Resources and Using Technology. The Resources section of the website provides access to a broad range of resources for use with young people experiencing mental health difficulties. Resources include fact sheets, digital stories and other online media, with many linked back to ReachOut.com. Using Technology offers practical ideas and advice for using different technologies in clinical practice by providing clinician reviews, interviews and step-by-step guidance. This section features a glossary of technological terms and seeks to 'bridge the digital divide' between young people and health care professionals. For more information see www.reachoutpro.com.au

When asked how professionals rated Reach Out over three quarters (83%) rated the site as being very good or excellent. Professionals report that fact sheets, ROC[65] and stories are the most useful elements of Reach Out. Nearly all professionals said they would refer both young people and colleagues to Reach Out. Reach Out is an innovative service that looks to the internet as a setting for health promotion and prevention, it can provide invaluable new supports to young people, as well as complement and strengthen existing community based youth services.

The results of the 2007 National Survey of Mental Health and Wellbeing indicate that we still have a way to go in making our services relevant and accessible to young people. [66] Reach Out is a valuable resource for professionals who wish to better understand and respond to the needs of a young audience. Inspire Foundation's experience with Reach Out urges that for mental health reform to be successful; clearly policy requires more than just a focus on face-to-face service delivery.

Inspire Foundation recommendations -TOR e)

In relation to workforce development:

1. New and emerging technologies, including the internet and mobile phones, 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;

2. Resources to build capacity of health care professionals to utilise ICT in their practice;

3. Increased resources for service providers to build capacity to deliver culturally sensitive and culturally specific responses (supporting mainstream suicide prevention initiatives) to individuals and communities at high risk of suicide and self-harm;

4. Increased support for community-based organisations to promote factors known to be protective for mental health and wellbeing (such as self-esteem, social connectedness and self-efficacy) to build community strength and the prevention of suicide and self-harm.

[65] Reach Out Central (ROC) is an interactive therapeutic game designed to help young people develop skills to support mental health such as problem solving, coping, communication and optimism. For more information see http://www.reachoutcentral.com.au/

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