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

I wish to submit the following brief comments to the Senate Standing Committee on Community Affairs inquiring into the impact of suicide on the Australian community.

In preparing for this submission, I reviewed literature on suicide available from a community-based library, and interviewed a number of people affected by suicide or suicide attempts. I also had discussions with a number of priests, pastors and chaplains, from a range of denominations and church traditions, who have had regular contact with people at risk of suicide, and those who have been affected by the suicide of relatives and friends. Some of the points that emerged are as follows.

In an average size local church of 150-200 members, and in contact with the local community, clergy could have about six or more counselling contacts per year with people who are depressed with suicide indicators, or with people who are on a suicide watch. The latter is particularly the case with ministers of religion in rural areas. To this should be added the many counselling contacts at funerals with grieving relatives and friends who don't normally have contact with a church.

All of the clergy I spoke to had completed post graduation mental health first aid and suicide prevention training of some sort, and were knowledgeable about the issues I had read in the literature.

Given the dozen or more church groups that can be found nearby in most local areas, and the trained and experienced resource they often have available, I was surprised to find that local churches are not given more consideration in the National Suicide Prevention Strategy. Local churches can often be seen as local mental health centres, providing healing for people's emotional needs, especially at times of crisis, while pastoring their spiritual life.

Families are usually the first to detect disturbing signs of behaviour and are in a position to take early intervention. They are the first to receive fire from the mentally distressed, and they are the first line of defence in suicide prevention. But despite reference to families in the National Suicide Prevention Strategy, at the home-level help is not getting through. The potential of family members in prevention is being insufficiently affirmed, supported and targeted. A common response from family members is, "We knew something was wrong, but we didn't know what to do or who to turn to."

Men, of course, are the high risk group, but for decades they have been on the neglected end of public policy, particularly in regard to family law. The recent reforms in regard to shared parenting should reduce suicides and suicide risk among men. These reforms should be consolidated, and attempts to repeal these reforms should be resisted. The recent government initiatives regarding men's health are welcome, but more research is needed on the detrimental and positive factors that

public policy has upon the emotional well-being of men. The restrictive gun laws introduced in 1996 have saved many men's lives and should be maintained.

Alcohol abuse, of course, is a common contributing factor on the path to suicide. The other specifically identified drug is marijuana. In public policy communications, this drug needs to be explicitly named along with alcohol, and not just bundled up in the term "illicit drugs".

One thing that is quite clear is that government-funded public eduction campaigns have been effective in reducing deaths in a number of areas, and it is now time to draw upon that experience and apply it to suicide prevention.

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