Senate Community Affairs Committee
Inquiry into Suicide in Australia

Submission
Suicide Prevention Australia
November 2009

*"We ourselves feel that what we are doing is just a drop in an ocean.
But the ocean would be less because of that missing drop."* - ***Mother Teresa***

Acknowledgments

The development of Suicide Prevention Australia's (SPA) submission to the *Senate Inquiry into Suicide in Australia* has benefited from the valuable input of a diversity of perspectives. SPA acknowledges the input of those members, trusted advisors and other stakeholders whose expertise and experience has informed and inspired this submission.

We would particularly like to thank those individuals who took the time to contribute to SPA's call for personal stories as well as those who have responded to SPA's various member and community consultations. Your contributions are greatly appreciated.

Thanks must also go to the many individuals who have previously contributed to the development of SPA's ongoing series of position statements (particularly former Reference Group members) and other SPA policy positions, including, most notably, members of the Suicide Prevention Taskforce.

A list of many of these individuals, as well as SPA members willing to be named in the submission, is included as Appendix A.

Finally, SPA acknowledges and appreciates the ongoing contributions of the SPA Board and SPA team members. In particular, sincere gratitude is expressed for the tireless efforts of SPA Chairperson, Dr Michael Dudley, Executive Officer, Ryan McGlaughlin, and Senior Project Officer, Jo Riley, without whom this submission would not have been possible. Thanks must also be expressed to freelance writer Katrina Clifford for her drafting of the submission.

SPA is supported by funding from the Australian Government under the National Suicide Prevention Strategy, and supports the Living is For Everyone (LIFE) Framework.

SPA endorses the principles of the Mindframe National Media Initiative in Australia, and the access to accurate information about suicide and mental illness and the portrayal of these issues in the Australian media.

Please note: the use of the term 'Indigenous' within this document refers to both Aboriginal and Torres Strait Islander people and communities, unless otherwise individually specified, and has been adopted after previous explicit community consultation on the issue of appropriate terminology.

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Foreword

Suicide Prevention Australia (SPA) commends the Senate's decision to refer the issue of suicide in Australia to a formal inquiry through the Community Affairs References Committee (the Committee) and thanks the Committee for taking the time to read and consider SPA's submission.

SPA is a non-profit, community organisation working as a public health advocate in suicide and self-harm prevention, intervention and postvention. SPA is the only national umbrella body active in suicide prevention throughout Australia, promoting:

- Community awareness and advocacy;
- Collaboration and partnerships between communities, practitioners, research and industry;
- Information access and sharing; and
- Local, regional and national forums, conferences and events.

As a national organisation, SPA supports and assists both individuals and organisations throughout Australia, by promoting collaboration and partnerships in suicide prevention, intervention and postvention. This includes, but is not limited to, SPA's formation of the Suicide Prevention Taskforce (to develop a proposal for a new accountability and governance structure for suicide prevention in Australia) and the National Committee for Standardised Reporting on Suicide.

[Please note: a concept paper prepared by ConNetica Consulting for the Suicide Prevention Taskforce and SPA has been lodged as a separate submission to the Senate Inquiry, as has a submission from the National Committee for Standardised Reporting on Suicide].

[More information on SPA's role in the suicide prevention sector in Australia is included later in Section iv) of the 'Introduction' to this submission].

SPA remains committed to representing those with lived experience and facilitating opportunities for the diversity of these voices to be heard in a safe and conducive environment. The de-identified extracts of personal stories submitted to SPA by both members and the public remain central to this submission. Many of these stories have been included in their more complete de-identified form as a confidential, non-public document at Appendix B of this submission.

While SPA does not necessarily endorse the comments made in these personal stories, we do believe that having been entrusted with them we have a responsibility to share them and honour the experiences and lessons of those who have taken the time and the courage to write them. These personal stories capture the true essence of the human experience of suicide.

In addition to the centrality of personal stories contributed by our members and others, a number of research and policy documents and commercial-in-confidence evaluation reports, developed through extensive stakeholder consultations and independent assessment, underpin the views expressed by SPA in its submission.

Many of these views and recommendations have previously been reflected in SPA's series of position statements on priority areas of suicide and self-harm prevention, intervention and postvention and SPA's Principles for Suicide Prevention; all of which are publicly available for download from the SPA website (http://www.suicidepreventionaust.org).

While we have aimed to produce a comprehensive response to each of the Terms of Reference (TOR) within the confines of this submission, SPA emphasises that the issues of suicide and suicide prevention in Australia are complex and far-reaching. We realise that the Committee will no doubt receive a significant number of submissions for review on these issues, and may be limited in the time it can contribute to its reading of each individual contribution.

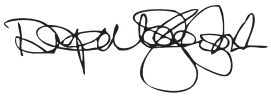
Bearing this in mind, SPA has attempted to be as succinct as possible in its responses while also considering the complexities of the issues covered by each TOR. We have referred the Committee to supplementary documents for further reading where appropriate, given the intricacy of the issue discussed or where reference to primary documents may add benefit to the Committee's consideration of certain matters.

This submission identifies a number of possible future strategic directions for suicide prevention in Australia as well as an overarching set of recommendations for systemic and social reform. These are listed by TOR and summarised in the Executive Summary of the submission.

In addressing each of the TOR, we have occasionally taken liberty with our responses to attend to issues not necessarily encompassed by the parameters of the TOR and Senate Inquiry, but of equal importance to the Committee's consideration of suicide and suicide prevention in Australia.

Finally, the Committee will note that a joint submission, *Suicide is Preventable*, funded and supported by various organisations involved in the suicide prevention sector, has been separately submitted to the Senate Inquiry. SPA is a co-signatory to this document, having jointly initiated its development with Lifeline Australia. SPA equally commends this submission to your reading, along with those of the National Committee for Standardised Reporting on Suicide and the Suicide Prevention Taskforce.

We thank you once again for the opportunity to comment as part of the *Senate Inquiry into Suicide in Australia*.



Mr Ryan McGlaughlin
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Suicide Prevention Australia

Dr Michael Dudley
Chairperson
Suicide Prevention Australia

Executive Summary

Every day, six to seven Australians die by suicide. For each person lost by suicide, there are approximately 30 others who have made a suicide attempt. In Australia, suicide and self-harm remain unacceptably high in the community with death at least 40% greater than that attributed to national road fatalities.

More recently, concerns have emerged over the under-reporting of suicide rates in Australia and the impact of this on understandings of risk and protective factors, policy formulation, preventative interventions and service provision for vulnerable individuals and communities. Analyses of National Coronial Information Service (NCIS) and Australian Bureau of Statistics (ABS) data reveal up to an estimated 30% under-reporting.

Suicide remains a complex phenomenon for which there is no single cause and no one solution. Deaths of this kind bear profound individual, familial, social and economic costs – not all of which can be effectively measured.

Beyond the toll to a person's mental and physical health and wellbeing, experiences with suicide can result in financial stress as a result of loss of employment, an inability to return to work, or the financial imperative to do so before an individual is ready. Estrangement from social networks, relationship breakdown, impediments to educational progress and study, family conflict (particularly relevant to ethnicity and cultural beliefs about suicide) and changes to religious or spiritual beliefs (producing personal discord in some instances and comfort in others) also feature strongly. For every suicide, it is conservatively estimated that, on average, another six people will be severely affected by intense grief.

The significant and far-reaching loss felt by those left behind, particularly family, friends and colleagues, is therefore immeasurable. The vicarious trauma and impact of suicide on first responders, coronial staff, clinicians, general practitioners and other health professionals, volunteers, witnesses and whole communities more broadly, should also not be underestimated. While the pain associated with each suicide and suicide attempt may be private, both remain major public concerns.

Finding ways in which to reduce suicide rates and the incidence of suicidal behaviours is therefore ***everyone's business***. For this reason, Suicide Prevention Australia (SPA) commends the Australian Government for its decision to refer this important issue to a formal inquiry and for providing interested organisations and individuals, particularly those with lived experience, an opportunity to contribute and have their voices heard.

The de-identified extracts of personal stories submitted to SPA by both members and the public remain central to SPA's submission. There are also a number of overarching principles, policy positions and priority areas of concern, formalised elsewhere in SPA's Principles of Suicide Prevention and the ongoing series of SPA Position Statements, which frame and guide the responses and recommendations within this submission.

However, this submission is more than simply an expression of these policy positions and philosophies. **It is also a call to action.**

More specifically, it is a call to action for:

- **The transformation of attitudes towards suicide and suicidal behaviour via a national suicide prevention awareness campaign that promotes understanding among the community.**

  The social and personal stigma associated with suicide remains a major influencing factor in the reluctance often exhibited towards help-seeking by many at-risk individuals. This may regrettably preclude successful suicide prevention and crisis intervention strategies. These types of attitudes and the punitive responses expressed by many health care professionals have major implications; one being the loss of contact with people who could otherwise be helped. Often, the ideas and prejudices surrounding suicide discourage people from talking about their suicidal thoughts.

- **A national whole-of-government and whole-of-community approach to suicide prevention underpinned by consistent and effective collaboration, coordination and communication between a range of agencies and services.**

  The issue of suicide in Australia requires a comprehensive and concerted effort on many fronts. A new national structure for suicide prevention could provide this opportunity by promoting the engagement of a wide coalition of stakeholders across the community to increase social impact, clarify roles and functions of various service providers and significantly increase the resources available for suicide prevention and related activities in Australia. SPA's vision for a coordinated approach anticipates a national suicide awareness campaign that takes its lead from previously successful community health campaigns, such as tobacco, HIV/AIDs and road trauma, to strongly promote messages of hope, help-seeking, resilience, social inclusiveness and wellbeing among individuals and communities. Mutually agreed ways in which to communicate, advocate and educate on the issues of suicide and self-harm in Australia require development.

- **Stronger recognition of the diversity of voices involved in the prevention of suicide and suicide attempts as well as greater inclusion of those with lived experience in research, policy, prevention strategies and service provision.**

  SPA believes an important way in which to counter the stigma so often associated with suicide and suicidal behaviours, without glamorising suicide itself, is to encourage others to listen to the many different voices and personal stories of those involved in suicide prevention and postvention; not least of all, suicide attempt survivors and those bereaved by suicide. Overarching concerns about inappropriate media reportage increasing suicide rates, and public discussion normalising suicide, must be balanced against the costs of silence about a major social problem. Engaging the voices of individuals with lived experience in policy, research and service provision can offer an invaluable opportunity to put a 'face' to suicide by remembering those lost to it, and may serve as an effective outlet for grief. Research also suggests that vulnerable individuals have the potential to influence many of their own health outcomes when actively involved in shared decision-making and the provision of quality information and appropriate self-management tools.

- **The charting of a long-term vision to promote the health and wellbeing of all Australians and the need to enhance community capacity and resilience in approaches to suicide prevention.**

  Investing in the capacity of communities so that they are empowered to play a role in shaping their own future is recognised universally as a key strategy to achieving safe, healthy and resilient communities. This should include robust public policy that, in particular, promotes the critical importance of early childhood and adolescent wellbeing and helps to build self-esteem and resilience towards adverse life circumstances by strengthening protective factors in the family and the community.

- **Improvements in support and funding of Australian-based suicide and suicide prevention research and evaluations, particularly of interventions.**

  The majority of suicide and suicide prevention research in Australia has traditionally focused on risk factors and quantitative data. There is currently little information about lived experience from those affected by suicide and those who provide services for them, or equally, understandings of internal suicidal processes. There has also been a paucity of evidence regarding what interventions work in suicide prevention. Allowing for appropriate cultural adaptations, international interventions could be costed and considered for application in Australian emergency departments and psychiatric wards post-discharge. A much deeper understanding is also required of people's capacity for resilience and optimism and the ways in which we might better develop pathways to hope and social cohesion in society. There is a manifest need to engage governments and other stakeholders in discussions with peak research funding bodies about prioritising the funding of suicide-related research. There also remains an imperative for vast improvements in the methods by which research findings are disseminated to practitioners and incorporated through collaborative and coordinated means into government policy.

- **Policies and services that more effectively respond to and meet the specific needs of high risk population groups and communities.**

  SPA argues that greater emphasis must be placed on the continuity of holistic care and 'safety nets' for individuals most at risk of suicide. Access should be provided to appropriate services for these individuals, wherever and whoever they are – through crisis, ongoing intervention and recovery phases. Many service providers, but particularly those in culturally specific communities, require increased resources to build their capacity to deliver adequate and accessible services and undertake targeted suicide prevention and mental health promotion activities and training; supporting mainstream suicide prevention initiatives. Development of 'best practice' standards and accreditation for all service delivery and training is essential. Additional strategies may include education and training of hospital staff with peer survivor training of health professionals more generally. At a minimum, more adequate support for psychiatric patients in public hospital emergency services is required by way of additional staff support and training in mental health and suicide prevention awareness. It is anticipated that the more harmful implications of stigmatising attitudes and punitive responses expressed by some health professionals towards suicide attempt survivors may diminish with greater understanding through improved training and support.

- **The development of "a community that values people and the quality of life; a nation where no-one believes suicide or self-harm is the only option for them" (SPA Vision).**

The case for reform is compelling. In Australia, at present, the suicide prevention sector remains in its infancy; providing an opportunity to establish a clear structure to support effective advocacy, fundraising, service delivery, and research that will, in turn, promote 'best practice' models of engagement and intervention. An additional benefit in the Australian context is that key people and organisations presently in the suicide prevention sector are highly engaged and committed to the development of a more effective, integrated national strategy that builds on the achievements of the sector to date.

SPA's advocacy for a renewed national community awareness campaign and new national structure for suicide prevention in no way overshadows these significant achievements and the effectiveness of many suicide prevention initiatives to date – a number of which have provided a solid foundation from which to develop greater consensus in the sector (and beyond) about communicating on the issues of suicide and suicide prevention, and an opportunity to more effectively address the need to provide greater ownership, engagement, transparency and accountability to and for the *whole of the Australian community*.

Summary of Recommendations (by TOR)

TERM OF REFERENCE a)

The personal social and financial costs of suicide in Australia

- 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.
- 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.
- Resourcing for the completion of a mapping exercise to collect, by postcode, ABS/NCIS and service provision data on suicide and self-harm in Australia to advocate for funding priorities determined by geographic need.
- Evaluate the ethical dimensions and strategic suitability of measuring economic costs of suicide relative to personal and social costs of suicide in Australia.

TERM OF REFERENCE 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 of suicide

- Standardised reporting, collection and capture, classification and coding of suicide-related data across Australian jurisdictions.
- Commission research to assess the resource and training implications of enhanced data collection and coding requirements for data stakeholders, assessing the potentially competing priorities of completeness, reliability and rapidity.
- Conduct an evaluation of newly-adopted ABS coding practices.
- There is a need for clearer portfolio responsibilities and resources for the mortality system in Australia, including the establishment of a central authority for mortality data production.
- Ensure comprehensive and standardised primary data on risk/demographic indicators, including identification of sexual orientation, gender identity and Indigenous suicides in the collection of data for purposes such as coronial records and reports prepared by police to assist coroners.
- Ensure consistent implementation of the use of the national standard Form 13 by police throughout all jurisdictions in Australia.
- Improve cross-jurisdictional communications and access to medical records.
- Ensure appointment, education and training of qualified and dedicated NCIS coders and police inquiry officers, with particular skills and/or familiarity in mental health and drug and alcohol.
- With leadership from Chief Coroners in each jurisdiction, improve consistency in coronial processes with regards to reporting on intent, including legislative clarity around the issue, consistency of terminology, and the possible introduction of graded coronial determinations of the likelihood of suicide and/or intent.
- Undertake collaborative work with coroners, forensic counselling services and those recently bereaved by suicide, to identify and examine those situations where suicide determinations may be at variance with families' wishes.
- Commission research to elucidate what aspects of the recent decline in Australian suicide statistics are due to real changes and which are due to artefact.

TERM OF REFERENCE c)

The appropriate role and effectiveness of agencies, such as police, emergency departments, law enforcement and general health services in assisting people at risk of suicide

- Develop and implement strategies aimed at de-stigmatising those affected by suicide and suicidal behaviours, including the promotion of improved understanding among first responders and health care professionals of the suicidal state and suicide bereavement.

- Ensure culturally sensitive grief and coronial support services to meet the specific needs of individuals and communities, including those of highly vulnerable population groups; most notably, Australia's Indigenous populations, but also those bereaved by suicide (particularly children and youth), men, people with mental illness and their families and friends, and gay, lesbian, bisexual and transgender (GLBT), immigrant, CALD, and rural and remote communities.

- Encourage proactive and standardised follow-up support and compassionate response during police investigations and coronial processes across all Australian jurisdictions. This should include the provision of information about support services available to families and friends bereaved by suicide, and a single point of contact for assistance during the coronial process.

- In consultation, create and trial improved support mechanisms for first responders, coronial staff, therapists, clinicians, (mental) health services staff and general practitioners following the suicide of a client or patient, to assist with their own grief and emotional responses and to prevent personal and professional burnout.

- Improve support mechanisms for witnesses of suicide and suicide attempt.

- Increased support of primary care physicians and general practitioners in the form of additional education, training and resourcing to assist in the development of improved suicide risk assessment and diagnosis times for early interventions to suicidal crisis.

- Improve training of all emergency department staff in current suicide risk assessment protocols.

- Increased funding, research and support to develop appropriate strategies and treatments to support suicide attempt survivors in emergency department settings.

- Improved completion of assessment documentation, duration and continuity of care (including integration at critical transitions of inpatient and community-based care) and ongoing risk monitoring, particularly of high risk individuals such as recently discharged psychiatric inpatients.

- Commission research to examine the work of individuals and teams who first respond to suicide and suicidal crisis, and their impact on future help-seeking by suicide attempt survivors and those bereaved by suicide. Especially investigate the role of peer support survivors.

- Commission research on developing working partnerships between emergency mental health services and crisis hotlines.

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

- Develop prison programs that focus on holistic suicide prevention and treatment strategies rather than solely end-stage strategies to avoid suicide attempts.

- Commission research on the impact of involuntary and solitary confinement of prisoners who attempt suicide.

TERM OF REFERENCE 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

- 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.

- 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.

- There is a need for informed debate and decision-making within the suicide prevention sector (and beyond) on ways in which to communicate, advocate and educate on the issues of suicide and self-harm in Australia. The outcomes require properly resourced evaluation.

- 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.

- Develop a national World Suicide Prevention Day (WSPD) Steering Committee to ensure that WSPD events and activities are integrated and coordinated under the banner of a national suicide awareness campaign, and engage all parts of the community, including regional and remote areas of Australia.

- Greater engagement of the suicide prevention sector with mainstream, community and multilingual media to raise awareness of suicide and how to responsibly report on suicide-related issues.

- Ensure programs related to the issue of suicide connect to other relevant social agenda issues, including homelessness, bullying, and substance abuse (drugs and alcohol), and the impacts of ongoing challenges such as the global financial crisis and climate change.

TERM OF REFERENCE e)

The efficacy of suicide prevention training and support for frontline health and community workers providing services to people at risk

- Implement improved mental health and suicide prevention training, education and supports for frontline (mental) health and community workers to recognise and assist people who are experiencing a suicidal crisis, and reduce stigmatising attitudes and behaviours towards suicide attempt survivors and the bereaved.

- Develop national accreditation and 'best practice' standards for all service delivery and training.

- Establish an independent national suicide prevention accreditation and standards agency, drawing on international 'best practice' standards, to manage the accreditation and evaluation of suicide prevention service delivery, training and programs.

- There is a need to examine the current evidence contributing to the effectiveness of suicide prevention service provision and interventions for at-risk individuals and those in crisis, with a view to revising (where necessary) current 'best practice' guidelines for frontline health and community workers.

- Develop timely, robust and transparent reporting systems to ensure information on suicide prevention programs is readily available and updated.

- Introduce quality assurance and training of bereavement support groups, and the promotion of evidence-based 'best practice' principles as the foundations for all suicide bereavement outreach services and postvention initiatives.

- Support accessible mental health first aid and suicide awareness training for the general community, but particularly 'first responders' in remote, rural and regional areas (e.g. small businesspeople, teachers, Rural Financial Counsellors, sports coaches) to allow independent referral of clients in crisis to the most appropriate and available mental health and health care services and resources. This should also involve acknowledging these individuals' own stresses and emotive responses to such crises, and reviewing means of obtaining personal support.

- Develop formal policies and strategies for institutions, such as schools, universities, workplaces and other community settings, to assist with the re-integration of suicide attempt survivors.

- 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.

- 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.

TERM OF REFERENCE f)

The role of targeted programs and services that address the particular circumstances of high risk groups

SPA strongly urges the Committee to review the recommendations specific to each high risk population group, as included in the SPA Position Statements, which are available for download from the SPA website (http://suicidepreventionaust.org/PositionStatements.aspx) or in hard copy format on request to SPA.

What follows is a selection of priority recommendations from each of the SPA Position Statements relevant to the role of targeted programs and services for high risk population groups, as required by TOR f).

- Ensure widespread adoption by services of strategies already proven to enhance treatment adherence and/or to reduce suicide and self-harm following an attempt, such as continuing regular postcards, continuing brief intervention with contact, information and training sessions for staff and patients, and treatment adherence troubleshooting.
- Improve responses to repeat and/or high lethality suicide attempters, and improved follow-up for psychiatric inpatients following discharge.
- Systematically introduce a national community visitors program to ensure immediate and continuing engagement with consumers following discharge from emergency departments for suicide attempts and inpatient psychiatric hospitalisation.
- Investigate the evidence contributing to the effectiveness and safety of first response teams.
- Ensure improvements in access to hospitals and services and timely available interventions for individuals experiencing suicidal crisis.
- Include families and friends (with the suicide attempt survivor's consent) in an individual's treatment and interventions.
- Develop strategies and resources to assist family members and friends in understanding the suicidal state and supporting suicidal people.
- There is a need for more rigorous monitoring of the incidence of suicide attempts.
- Encourage greater identification and recognition of *suicide postvention* as a *suicide prevention strategy*.
- Introduce mandatory suicide (and attempted suicide) postvention guidelines across all Australian educational institutions and schools, as well as initiatives that assist in improving the communication of grief, loss and suicide bereavement among children and adolescents.
- Promote the potential benefits (and risks) of the internet and online social mediums as a non-confrontational means of support, particularly for at-risk and bereaved individuals who are geographically isolated or are seeking anonymity and privacy or 24-hour availability.
- Develop a mentoring system for general practitioners, nurses, allied health and other support workers to enable regular debriefing during the establishment and implementation of suicide prevention strategies in rural and remote areas.
- There is a need for better understanding of barriers to health care and mental health services, and the funding and development of alternative models that address these barriers (e.g. innovations in information technology, peer support and respite houses).
- Introduce training for teachers and students to identify and respond to bullying and harassment, especially on the grounds of minority group membership generally, and sexual orientation and/or gender non-conformity specifically.
- Develop a national anti-bullying campaign (similar to Australia's domestic violence campaign) focused particularly on bullying in schools and the workplace and on the grounds of gender and sexual orientation, and cyber-bullying.
- Review and support demonstrably effective programs targeting depression, substance misuse and/or suicidal behaviours among young people, with a view to demonstrating and disseminating their effective suicide prevention potential.

TERM OF REFERENCE g)

The adequacy of the current program of research into suicide and suicide prevention, and the manner in which findings are disseminated to practitioners and incorporated into government policy

- Engage governments, peak research funding bodies such as the NHMRC and ARC, the Centre for Excellence in Suicide Prevention, and other stakeholders in discussions to develop a national suicide and suicide prevention research agenda in Australia, and to improve funding and systematic review of priority-setting for Australian research in the field of suicide prevention and intervention (with particular attention to intervention research).

- Encourage a broadening of the evidence base to diminish the gap between empirical research and 'real world' application (e.g. incorporating the lived experiences of suicide attempt survivors and bereaved individuals).

- To ensure evidence of effectiveness, establish partnerships between universities, and government, philanthropic and business organisations, to apply academic expertise to the evaluation of service delivery and related projects throughout the life of projects.

- Initiate mentoring programs for those engaged in project and program evaluations, to train researchers and to develop successful cultures of evaluation.

- Examine the effectiveness of competitive tendering for research funds, especially as it applies to funding based on needs, and the extent to which it promotes collaboration between researchers and sector organisations in environments where there is a paucity of research funds.

- Conduct a comprehensive evaluation of suicide prevention policies, programs and services in Australia, and ensure suicide-related research continues to focus on attempted suicide as well as completed suicide.

- Ensure intervention studies and epidemiological studies of risk and protective factors and people's capacity for resilience are made priorities of the national research agenda.

- Undertake a systematic review of international interventions to assess effectiveness, costing and applicability in Australian emergency departments and psychiatric wards post-discharge.

- Address the 'gaps' in current suicide-related research, as outlined in the body of SPA's response to TOR g), by including these as priorities on the national research agenda.

- Direct research efforts towards addressing the circumstances of those who do not present to health and community services, as well as those who do, to inform targeted help-seeking initiatives for individuals at risk of suicide and to ensure services are optimally responsive.

- Improve the methods by which research findings are disseminated to practitioners and incorporated through collaborative and coordinated means into government policy.

- Communicate research findings to stakeholders in meaningful ways that encourage individuals to become "effective community agents in the area of suicide prevention"; raising the profile of suicide as a social issue.

TERM OF REFERENCE h)

The effectiveness of the National Suicide Prevention Strategy in achieving its aims and objectives, and any barriers to its progress

- Establish structures of governance and accountability in the suicide prevention sector that are potentially independent of government and service agencies.
- Ensure ongoing transparency of policy formulation and tendering processes related to the *NSPS*.
- Ensure funding of suicide prevention projects is commensurate with the social and economic costs of suicide on the Australian community.
- Broaden the funding base for suicide prevention projects and interventions by raising and distributing funding from across the community and from a wide variety of sources.
- Service delivery, capacity building, community awareness and education, and advocacy need to be appropriately resourced and not reliant on ad hoc funding arrangements.
- Consider doubling current government expenditure on national suicide prevention projects in Australia.
- Shift funding priorities 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*.
- Continue to improve collaboration and joint planning between national and state/territory suicide prevention strategies and projects, as well as between the states and territories and community organisations.

Too soon

So sad the loss
Of a well-loved voice
So deep the cut (in our hearts)
Of an unfortunate choice

A person with spark – temporarily hidden
By a blanket of dark

Ripped away too soon
Before the fullness of the season,
Before the light in their eyes
Could return to the room

- Personal poem submitted to SPA, Submission 041

Senate Community Affairs Committee Inquiry into Suicide in Australia

"We ourselves feel that what we are doing is just a drop in an ocean. But the ocean would be less because of that missing drop." – Mother Teresa

Introduction

Every day, six to seven Australians die by suicide. For each person lost by suicide, there are approximately 30 others who have made a suicide attempt. Yet suicide remains a *largely preventable* global health problem.

In spite of this, suicide is one of the leading causes of death globally and in Australia. The World Health Organization (WHO) estimates that one million people die in the world every year by suicide. In Australia, suicide and self-harm remain unacceptably high in the community with death at least 40% greater than that attributed to national road fatalities.

While suicide occurs in and affects all age groups and people from all walks of life, statistics show that, in Australia, those most frequently lost by suicide are young men, though men over 75 years are also potentially at high risk. Indigenous suicide rates for young males in some remote communities are up to four times higher than comparable non-Indigenous rates. Self-harm is a leading cause of morbidity, especially for young women.

More recently, concerns have emerged over the under-reporting of suicide rates in Australia and the impact of this on understandings of risk and protective factors, policy formulation, preventative interventions and service provision for vulnerable individuals and communities. In response to this issue, SPA has played a fundamental role in establishing a National Committee for Standardised Reporting on Suicide.

[More information on the National Committee for Standardised Reporting on Suicide, including a list of the group's aims, is incorporated into SPA's response to TOR b)].

References to suicide in the context of suicide prevention research therefore typically relate to *identified* or *reported* suicides, although:

> *"Not everyone who thinks about or attempts suicide comes to the attention of police or hospitals. Some people don't make a serious attempt even though they regularly think about it or consider it. Some people harm themselves with no intention of dying".*
>
> ***-- Personal story submitted to SPA, Submission 008***

Regardless of the estimated shortfall in published suicide data compared with the actual incidence of suicide in Australia, there remains little doubt that an urgent need exists for coordinated and intensified widespread action to prevent this needless toll.

Indeed, suicide and self-harm both bear profound individual, familial, social and economic costs. For every suicide, it is conservatively estimated that, on average, another six people will be severely affected by intense grief (Clark and Goldney, 2000; Clark, 2001). The significant and far-reaching loss felt by those left behind, particularly family, friends and colleagues, witnesses, first responders, clinicians, general practitioners and other health professionals (including coronial staff), is immeasurable. There are 84 recorded hospital separations each day in Australia for intentional self-harm (Australian Institute of Health and Welfare, 2009). While the pain associated with each suicide and suicide attempt may be private, both remain major public concerns.

Finding ways in which to reduce suicide rates and the incidence of suicidal behaviours is therefore ***everyone's business***. All Australians, at all levels of community, industry and government, must share in the collective responsibility of working together to address the issue of suicide through suicide prevention.

i. The complexities of suicide and reluctance towards help-seeking

Suicide and suicidal behaviours typically occur in response to a range of potential social, psychological, situational, biological and illness-related causes, which isolate people and erode their hope. Suicide can therefore be said to be a complex phenomenon for which there is no single cause and no one solution.

> *"When you are suicidal you seem to have lost your sense of purpose in life and there seems to be no hope that you could ever regain that sense of purpose. Whilst I felt guilty for feeling suicidal because it wasn't fair to my son, I kind of justified my guilty feelings by thinking that my son would be better off without me anyway".*
>
> ***-- Personal story submitted to SPA, Submission 009***

> *"I try and get up everyday, I try and keep myself busy otherwise I dwell too much on my losses and start heading down the same path again".*
>
> ***-- Personal story submitted to SPA, Submission 010***

> *"If you had said to me, prior to 2000, who would be the LAST person in the world who could be so badly depressed that getting out of bed in the morning was impossible and that level of depression would lead to thoughts of suicide, I would have said me. Yet, there I was in the deepest, blackest, darkest place I have ever been in my life with basically no real hope of getting out of there".*
>
> ***-- Personal story submitted to SPA, Submission 015***

> *"My son's best friend hung himself last week. He was 18. He had substance abuse problems (mainly alcohol), no job, no aspirations, and impending court cases resulting from his irresponsible behaviour while drunk…He left school at 16, with no qualifications of any type. So what then were his options?…At 18, he felt washed up, with no sense of direction or purpose…At present, I am not only in the anger stage of grief over my son's friend, but objectively, rationally, I see a basis for anger and legitimate blame – the bureaucratic systems set up to deal with young people (and especially young males) are often wholly unsympathetic. This young man may have been marginalised, but he did not suffer a recognised mental health problem, so did not get emotional support".*
>
> ***-- Personal story submitted to SPA, Submission 045***

It follows then that, though mental illness remains one of the most common contributing risk factors to suicide, both suicide and suicide attempt should not be approached and treated as (only) psychiatric or health-related problems. Pathways to care for at-risk individuals must not be restricted to those of a clinical context alone for fear of failure to identify and remedy the possible social determinants of suicide and suicidal behaviour. For example, (mental) health professionals may bear a greater chance of intervening in the progression of suicidal ideation to suicide attempt if they are able to identify other recent instances of situational, emotional or interpersonal precipitating risk factors, such as "upsetting social interactions, diagnosis of a disabling physical illness or recent job losses" (Fairweather et al., 2006, p. 1243).

The importance of social inclusion and connectedness (particularly through peer support networks) as protective factors towards suicide risk must also not be underestimated. Research that seeks to better understand and evaluate the risk and protective factors for different population groups is therefore vital to the development and delivery of effective suicide prevention strategies and interventions.

> *"His isolation meant that we couldn't engage with him and he couldn't reach out. I know community is the hardest thing to create, but his isolation let his situation fester".*
>
> ***-- Personal story submitted to SPA, Submission 028***

"Meeting my group changed my entire life. At the time I joined the group, I was not functioning effectively in my day-to-day life. I felt vulnerable and, although I had lots of supportive friends and family, I felt alone with this loss. The group enabled me to talk every two weeks for an entire evening, with people that understood through their own similar loss, and I was able to discuss all of my emotions, my current state, what had happened since we last met…every time we met. After the group, we wanted to stay connected and not lose this mutual support which we all benefited from".

-- Personal story submitted to SPA, Submission 029

"…my view is we must keep the conversation alive to keep the person alive. Peer support is critical; those that have attempted suicide and are here to share the experience of coming back from that choice are essential weapons of the power of their story to be given to those that believe there is no choice".

-- Personal story submitted to SPA, Submission 068

At present, requisite care, treatment and ongoing support services for at-risk individuals (particularly suicide attempt survivors and those bereaved by suicide) remains largely deficient in Australia. While many individuals may require specialist management, treatment with medication and/or intermittent use of health care services, the gap between presentation of symptoms and their treatment (or continuity of care where it is sought) is immense. The most recent *National Survey of Mental Health and Wellbeing*, for example, shows little if any progress on increasing access to mental health services – only around 35% of people with a need for mental health care received any care while 65% of people with a need for mental health care go untreated (Australian Bureau of Statistics, 2007).

One likely explanation for this is that, despite improvements in mental health literacy (e.g. via awareness-raising campaigns such as those of *beyondblue: the national depression initiative*), there have typically been fewer correlative changes in appropriate treatment behaviours among those most in need. This may be attributable to the misconceptions and enduring stigma surrounding suicide and suicidal ideation, which can lead to family tensions (including the concealment of cause of death in the case of suicide) and can discourage help-seeking among vulnerable population groups.

"An unexpected consequence [of a newspaper story about the suicide of a local woman] was a fierce complaint from XX's mother – not because we [the newspaper] had exposed the reasons behind her daughter's desperate and preventable depression, but because the mother had told her friends that her daughter had died of a heart attack. Therein lies a consequence of the shame and secrecy that surrounds suicide…"

-- Personal story submitted to SPA, Submission 091

Another possible inhibitor towards help-seeking among high risk population groups may be the cost and availability of access to appropriate (mental) health services and support networks, particularly for at-risk rural and remotely located Australians. The lack of coordination and collaboration between services is also particularly evident within the suicide prevention sector.

"The farming community in Australia are a strong and resilient group of people. They are also a hidden population in terms of the incidence of suicide".

-- Personal story submitted to SPA, Submission 092

"The care and understanding of both these people [support group] in the early stages convinced me that it was necessary for me to travel to Sydney for the group sessions. It was fortunate for me that my sister lived there and could offer me accommodation. I fear that for others who live in the country it would not be so easy and that they would not have the opportunity to attend any group sessions. The group experience itself was a major factor in the positive outcome for myself. Being able to share my feelings with the other group members, and at the same time empathise with them was a significant factor".

-- Personal story submitted to SPA, Submission 038

SPA argues that greater emphasis must be placed on both access to and continuity of holistic care and 'safety nets' for individuals most at risk of suicide. This calls for greater professional responsibility, accountability and response to at-risk individuals throughout the 'chain of care' and social support (which may not always be linear) during suicidal ideation, suicide attempt or suicide bereavement. Over time, an individual's needs may change. Vulnerable individuals must therefore feel assured that a breadth of services will be both available and accessible to them as required, and that these services can be accessed again later, if necessary. Timely intervention and the offer of ongoing support can alleviate much distress.

This highlights the need also for 'proactive' programs that seek to identify those who may be at risk, but who do not necessarily self-identify as such, and need to be encouraged in their help-seeking. This is particularly pertinent to instances where social determinants of suicide and suicidal behaviour may be (under)identified risk factors – e.g. for men at times of marital separation and in the context of family law disputes. Programs to target such vulnerable men have already commenced in some Australian jurisdictions. For example, the Family Law Courts have taken steps to increase the awareness at all levels of the courts' operations of the risks of suicide and the referral to pathways of care through completed programs such as the Mental Health Support Project and the Integrated Client Service Delivery Program (Family Law Courts, 2009).

Similarly, Dads in Distress (DIDs), a national support network of peer support groups for men (http://www.dadsindistress.asn.au), aims to stem the trend of male suicide due to the trauma of divorce and separation from children. These programs are to be commended and considered as potential models on which to base further 'proactive' suicide prevention programs that respond to the specific needs of other high risk population groups.

[Further examples of effective suicide prevention programs and services targeted towards the particular circumstances of high risk groups (men included) have been addressed in SPA's response to TOR f)].

There are many individuals within our community that continue to face significant challenges with regards to suicide and suicidal behaviour and inhibitors to help-seeking. For instance, the alarmingly high occurrence of suicide among Indigenous populations and the service gaps frequently experienced by at-risk individuals suffering from comorbidity (e.g. substance misuse and mental health problems) are but two substantial causes for concern.

SPA acknowledges that the TOR of the *Senate Inquiry into Suicide in Australia* have asked participants to respond specifically to the impact of suicide on the Australian community, with particular reference to high risk groups such as Indigenous youth and rural communities. However, SPA would like to highlight that a number of other high risk groups for suicide exist, which it considers are equally deserving of attention and response.

SPA has previously identified and examined the challenges inherent to a number of these groups through its ongoing series of SPA Position Statements, which are publicly available for download from the SPA website: http://suicidepreventionaust.org/PositionStatements.aspx.

[Please note: copies of each SPA Position Statement are also available in hard copy format on request to SPA, should this be the preference of the Committee].

These groups have included: Indigenous populations; people in rural and remote communities; those experiencing mental illness (particularly psychiatric inpatients); individuals bereaved through suicide; gay, lesbian, bisexual and transgender (GLBT) people; and suicide attempt survivors. A number of these SPA Position Statements have also indirectly addressed the issues inherent to youth as well as older Australians.

SPA suggests to the Committee that it may be premature to prioritise those high risk groups referred to in the TOR over other high risk population groups, particularly since little evidence-based evaluative research exists to inform what works and what does not work in terms of suicide prevention for any particular target group (Robinson et al., 2008). There also remains much debate worldwide about the accuracy of official national suicide statistics, although in Australia, there is evidence to suggest frequent under-identification of Indigenous status at death. Similarly, GLBT status is also seldom recorded, despite the over-representation of these groups in suicide and self-harm statistics.

It is with these qualifiers in mind and within this context that SPA has addressed the TOR outlined by the Committee as part of its inquiry into suicide in Australia.

ii. Social stigma and the power of personal stories and lived experience

Undoubtedly, the social and personal stigma associated with suicide remains a major influencing factor in the reluctance often exhibited towards help-seeking by many at-risk individuals. This may regrettably preclude successful suicide prevention and crisis intervention strategies.

> *"I don't talk about it because I don't want people to think I'm broken".*
>
> ***-- Personal story submitted to SPA, Submission 008***

> *"For a long time I felt intense embarrassment… about attempting to commit suicide…I found that suicide was still very much a taboo issue within society and I felt guilt and shame associated with it. It would be great if we could be more open and honest about this issue within society as it affects many people. Perhaps if we could speak more freely and honestly, we could prevent the devastation caused by suicide".*
>
> ***-- Personal story submitted to SPA, Submission 014***

> *"We live a daily horror that we can't share or discuss with anyone else…I feel like I am on a merry-go-round that will not stop and I cannot get off".*
>
> ***-- Personal story submitted to SPA, Submission 024***

SPA believes an important way in which to counter the stigma so often associated with suicide and suicidal behaviours, without glamorising suicide itself, is to encourage others to listen to the many different voices and personal stories of those involved in suicide prevention and postvention (not least of all, suicide attempt survivors and those bereaved by suicide) with a view to incorporating these experiences into policy development, research and practical interventions.

> *"Maybe a way to demystify suicide is by telling real stories of how suicide affects people or an awareness of why suicide occurs in the first place? I think there is a tendency to want to ignore the specific grief and loss from suicide and I think these truths are not made apparent on a societal level".*
>
> ***-- Personal story submitted to SPA, Submission 039***

Engaging the voices of individuals with lived experience in policy, research and service provision can offer an invaluable opportunity to put a 'face' to suicide by remembering those lost to it. The Salvation Army's *Hope for Life National Lifekeeper Memory Quilt* is a practical example of this. Encouraging people to tell their stories can also serve, however, as an effective outlet for grief and may assist in the individual healing process. The Committee may be interested to note that close to 90% of respondents to SPA's call for personal experiences with suicide endorsed this position, with many suggesting that the act of sharing personal stories could often be therapeutic; particularly for the bereaved.

> *"Talking about it does help. I don't know how I want to be heard, but I do".*
>
> ***-- Personal story submitted to SPA, Submission 080***

> *"The topic of suicide needs to be taken out of the shadows. Make the people who die this way, come alive by telling their stories. Make them more than a statistic. Doing so would help to alleviate the unspoken sense of shame about [this] way of death…Writing this submission has helped, because I do not want his [friend] death to be in vain and because it is a way to honour his presence in my life".*
>
> ***-- Personal story submitted to SPA, Submission 039***

"I hope that my story will provide you with some insights of what it is to lose a loved one through suicide and how it impacts on their lives. I would also like to say thanks for the opportunity to share my innermost thoughts and say that, even though it brought back a lot of memories, it felt very therapeutic to be able to do this".

-- Personal story submitted to SPA, Submission 051

Research has also suggested that vulnerable individuals have the potential to influence many of their own health outcomes when actively involved in shared decision-making and the provision of quality information and appropriate self-management tools. This has previously been demonstrated by people with chronic diseases who have taken an active role in their own health care plans (Whitehead & Dalhgren, 2007).

"I have seen first hand how just being listened to, without judgement or advice puts a person back in control of their own lives. Believing in someone and in their ability to help themselves gives them the belief that they are able".

-- Personal story submitted to SPA, Submission 094

However, many individuals (particularly suicide attempt survivors and those who have experienced suicidal ideation) report feeling excluded from suicide prevention, despite their unique insight into the issues involved (Litts et al., 2008). This is also often in spite of a general willingness by many of these individuals to share their experiences of suicide or suicide attempt.

SPA was surprised, for example, by the response to its call for personal stories, conducted as part of its stakeholder consultations during the development of this submission. Over a two-week period, we received close to 100 very detailed, candid and poignant personal submissions from SPA members, members of the public, and professionals involved in the suicide prevention sector.

[Please note: many of these personal stories have been included in de-identified form in a confidential, non-public reference document attached as Appendix B to this submission for the Committee's review].

SPA believes the contribution such insights and diverse experiences can offer to not only research, but also policy, prevention strategies and service provision should not be underestimated, but should be more broadly recognised and incorporated into treatment, interventions, and prevention strategies.

"Suicidal compulsions are worth expressing. Stop hiding suicide from public view. We need not be frightened that this will lead to 'more suicide'. Instead, it will give alternative expression to the idea than is offered by the act itself".

-- Personal story submitted to SPA, Submission 001

"When something is kept secret, it fuels itself on darkness and shame, but if we can expose it in the light, where can it hide? I believe we CAN bring suicide out of the darkness, and that perhaps a good place to start is by telling our stories, and having our voices heard. It is my opinion…that WE are the experts. We have knowledge and insight that only comes from lived experience…We need not only to be included in suicide prevention research, but be central to it".

-- Personal story submitted to SPA, Submission 082

iii. Suicide prevention in Australia

Australian governments, communities and organisations have supported suicide prevention efforts for many years, with a series of national suicide prevention initiatives that began in the mid-1990s. At this time, Australia was among the first countries to develop a national strategic approach to suicide prevention.

Funding of suicide prevention initiatives nationally and across both states and territories falls under the auspices of Australia's *National Suicide Prevention Strategy (NSPS)*. The strategic framework guiding the *NSPS* has been (and remains) the *LIFE Framework*. Investing in the capacity of communities so that they are empowered to play a role in shaping their own future is recognised universally as a key strategy to achieving safe, healthy and resilient communities. This has been the cornerstone for many of the national and state/territory approaches to suicide prevention in Australia (ConNetica Consulting for the Suicide Prevention Taskforce and SPA, 2009).

[Please note: the concept paper prepared by ConNetica Consulting for the Suicide Prevention Taskforce and SPA, which has been submitted separately to the Senate Inquiry, deals with these issues in greater detail].

Recent examples of continuing improvement in suicide prevention and the development of initiatives aimed at enhancing support, service delivery and outcomes for at-risk individuals and communities, while also raising awareness of the prevalence of suicide in Australia more generally, include (but are by no means limited to):

- Advancement of major national education and awareness-raising campaigns in the area of mental health and wellbeing (e.g. *MindMatters* and *beyondblue: the national depression initiative*);
- Development of voluntary guidelines for media coverage of suicide, self-harm and mental illness (advanced primarily through the *Mindframe National Media Initiative in Australia*);
- Development of mental health and e-mental health programs for young people (e.g. *Reach Out*, *headspace*) and increased use of information technology by at-risk population groups more broadly;
- The Access to Allied Psychological Services (ATAPS) scheme, which enables GPs under the *Better Outcomes in Mental Health Care Program* to refer consumers to allied health professionals who deliver focused psychological strategies;
- Telephone counselling and information services for at-risk individuals, such as Lifeline, Kids Helpline, and MensLine Australia;
- Workplace-based early intervention suicide prevention and social capacity building programs central to the work of OzHelp Foundation;
- Lifeline Australia's workforce development project, *Suicide Bereavement Support Group Standards & Practice Project*; and
- Community-based mental health literacy and suicide intervention training programs, including *LivingWorks* and the *Mental Health First Aid* program.

iv. The role of SPA and the rationale for a new approach to suicide prevention

As the peak advocate body within the suicide prevention sector in Australia, SPA has similarly maintained a focus on continuous review and improvement of its own operations and activities, particularly over the past five years. During this time, the organisation has introduced significant reforms to its governance structures; cultivated an enormous amount of goodwill among members and key stakeholders; and recorded a number of notable achievements in thought leadership and strategic collaboration with other organisations in the suicide prevention sector.

As part of its policy and advocacy agenda, SPA regularly publishes position statements on priority areas of suicide and self-harm prevention, intervention and postvention in Australia. These foundation documents provide a basis for understanding, discussion, teaching, delivery and research, and reflect the diversity of voices within the sector.

These documents are not intended to be specific to or limited to policy-makers alone, but are instead written with a general cross-section of the educated lay public in mind (i.e. broader community, media, and other NGOs). SPA Position Statements therefore represent a starting point for policy and strategy development, while supporting SPA's ongoing advocacy work and activities.

Central also to this is a regular program of events, which SPA hosts each year to coincide with World Suicide Prevention Day (10 September), including the annual SPA Community Forum; a free event open to the public featuring presentations and panel discussions involving a number of people affected by suicide with a focus on the year's World Suicide Prevention Day international theme and the principles of open dialogue and help-seeking. The program culminates in the annual *LIFE Awards* gala ceremony; an invitation-only event recognising the outstanding achievements and contributions made to suicide and self-harm prevention, intervention and postvention in Australia across a number of awards categories. In 2009, the *LIFE Awards* received increased nominations across its awards categories as well as notable media coverage.

A selection of SPA's other (recent and ongoing) achievements not previously alluded to in any detail is included below for the Committee's reference.

[Please note: these achievements should also be considered in the context of SPA's response to TOR d)].

- Joint formation of the Suicide Prevention Communications Think Tank with partners such as Lifeline Australia to seek a national consensus on communicating about suicide and self-harm;
- *Achieving standardised reporting of suicide in Australia: rationale and program for change* article accepted for publication in *Medical Journal of Australia* (in press);
- Continued facilitation of broader community engagement, dialogue and awareness-raising on the issues of suicide and suicide prevention through a range of SPA-hosted and co-hosted events. Previous major highlights have included:
    - SPA National Conferences.
    - National Forum on Men and Suicide (2006), co-hosted by Crisis Support Services Inc – Mensline Australia.
    - Inaugural Aboriginal Suicide Prevention & Capacity Building Workshop (2007), co-hosted by the Suicide Prevention Section of DoHA.
- Successful joint bid to host the 2010 Asia-Pacific IASP Regional Conference with AISRAP (Australian Institute of Suicide Research and Prevention) in Brisbane, 17-20 November 2010; and
- Participation in additional collaborative suicide prevention sector initiatives and the development of information resources, including:
    - Involvement with the RU OK? Day Steering Committee; particularly advocating for wider participation of key sector organisations.
    - Involvement in the development of the YMCA of Sydney's Promoting Mental Health & Wellbeing Project.
    - Launch of the *Working with Warriors* DVD, produced by Wheatbelt Men's Health Inc and the Kondinin Group to assist farmers and their families to understand rural men's mental health.
    - Launch of the new Western Australian Suicide Prevention Strategy 2009-2013 and announcement of the new WA Ministerial Council for Suicide Prevention.
    - Consensus statement on loss and grief, jointly issued by eight of Australia's helpline support service providers and peak bodies concerned with mental health and suicide prevention.

More information is available via the SPA website: http://www.suicidepreventionaust.org

Many of these projects have been achieved on minimum resources and nominal funding – both of which have limited, and continue to do so, SPA's capacity as the national advocate for suicide and self-harm prevention, intervention and postvention in Australia. In spite of this, feedback shows that the vast majority of stakeholders believe SPA has made (and continues to make) a noteworthy contribution to the national suicide prevention agenda in Australia, though the organisation may not have always consistently communicated these achievements as effectively as possible to its stakeholders (ConNetica Consulting, SPA Evaluation, 2008). On this basis, SPA continues to make a case for increased funding to recruit additional staff with expertise to drive SPA's media and member communications and engagement, and to support the organisation's increasing research and policy development agenda and activities.

> *"As the peak national body, SPA is providing outstanding leadership, advocacy and support for individuals and organisations across Australia, across diverse disciplines and communities; and despite limited resources, has made steady progress in building the new partnerships and collaborations needed to reduce the high rates of suicide and self-harm within Australia".*
>
> ***– Her Excellency Ms Penelope Wensley AO, Governor of Queensland***

In 2008, a comprehensive independent evaluation of the performance of SPA against the objectives of the organisation's Strategic Plan 2005-08 was conducted by ConNetica Consulting. The review included extensive consultations and evaluations with a wide range of members and other key stakeholders.

Central to the new SPA Strategic Plan (2008-10) was the need to advocate for and lead the development of new national structures to more effectively address suicide awareness and suicide prevention, intervention and postvention

service provision in Australia. In May 2008, SPA established a 'taskforce' (collectively referred to as the 'Suicide Prevention Taskforce') of individuals and organisations committed to these objectives to drive this agenda.

[Please note: membership of the Suicide Prevention Taskforce is listed at Appendix A of this submission, along with the names of members of the SPA Position Statement Reference Groups and those SPA members willing to be named in SPA's independent submission to the Senate Inquiry].

Clearly, the issue of suicide in Australia requires a comprehensive and concerted effort on many fronts. The Suicide Prevention Taskforce proposes that a new national structure for suicide prevention could provide this opportunity by promoting engagement of a wide coalition of stakeholders across the community to increase social impact, clarify roles and functions of various service providers and significantly increase the resources (including funding from non-government sources to supplement the current contributions of governments) available for suicide prevention and related activities in Australia. A new national structure may also more effectively address the need and opportunity to provide greater ownership, engagement, transparency and accountability to and for the Australian community, as well as assisting the community to understand clearly where to go to get the services they need to financially support this crucial social issue (ConNetica Consulting for the Suicide Prevention Taskforce and SPA, 2009).

A range of models from both Australia and overseas related to suicide prevention, HIV prevention, road safety and breast cancer offer potentially sound bases for this rationale; clearly demonstrating that clarity of roles and responsibilities and increased ownership of community sector-led health campaigns ensures that scarce resources are well utilised and effectiveness is increased. As the Suicide Prevention Taskforce and SPA have jointly pointed out, a key benefit in Australia at present is that the suicide prevention sector remains in its infancy, providing an opportunity to establish a clear structure to support effective advocacy, fundraising, service delivery, and research that will, in turn, promote 'best practice' models of engagement and intervention.

An additional benefit in the Australian context is that key people and organisations presently in the suicide prevention sector are highly engaged and committed to working collaboratively to minimise duplication of effort and confusion for consumers. Many of these groups are also committed to the development of a more effective, integrated national strategy that builds on the achievements of the sector to date (ConNetica Consulting for the Suicide Prevention Taskforce and SPA, 2009).

A range of structural options to achieve these objectives is addressed in the concept paper, *Let's Get Serious: The Infrastructure to Effectively Address Suicide in Australia – A Submission to the Senate Community Affairs Committee Inquiry on Suicide in Australia*. SPA commends this document to the Committee for reading, and asks that the Committee remain mindful of such proposals (as well as those of the National Committee for Standardised Reporting on Suicide and the joint sector submission, *Suicide is Preventable*) while considering SPA's independent responses to the TOR proposed by the *Senate Inquiry into Suicide in Australia*.

Key points to highlight:

- Every day, six to seven Australians die by suicide. For each person lost by suicide, there are approximately 30 others who have made a suicide attempt. There are 84 recorded hospital separations each day in Australia for intentional self-harm.
- In Australia, suicide and self-harm remain unacceptably high in the community with death at least 40% greater than that attributed to national road fatalities.
- For every suicide, it is conservatively estimated that, on average, another six people will be severely affected by intense grief.
- Finding ways in which we can reduce suicide rates and the incidence of suicidal behaviours is *everyone's business*.
- Suicide is a complex phenomenon for which there is no single cause and no one solution.
- Suicide and suicidal behaviour arise from an intricate range of possible social, psychological, situational, biological and illness-related causes, which isolate people and erode their hope.
- Rigorous research into and understandings of risk and protective factors for different groups and environments, and particularly research regarding effective interventions, is vital to effective response and the tackling of social exclusion among vulnerable individuals and communities.
- Greater emphasis must be placed on access to and continuity of holistic care and 'safety nets' for individuals most at risk, including suicide attempt survivors and those bereaved by suicide.
- An important way in which to counter the stigma so often associated with suicide and suicidal behaviours is to encourage others to listen to and embrace the many different voices and personal stories of those affected by suicide and self-harm. The act of sharing personal stories can often be therapeutic; particularly for the bereaved.
- Despite minimum resources and nominal funding, SPA has played an active role in promoting collaboration and partnerships between sector stakeholders and the community on priority issues related to suicide prevention, intervention and postvention.
- Suicide prevention in Australia requires effective coordination and communication between a range of agencies and services to minimise duplication of effort and confusion for consumers.
- A new national structure may more effectively address the need and opportunity to provide greater ownership, engagement, transparency and accountability to and for the Australian community with regard to this crucial social issue.

Terms of Reference (TOR)

a) The personal, social and financial costs of suicide in Australia

The profound effects of suicide may be likened to a stone thrown into a lake in that the ripples that radiate have 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.

> *"…each morning I wake up and wonder how I will get through the day knowing I will never see him [son] again. This sort of tragedy happens to other people, only I realise now I am the 'other people'".*
>
> ***-- Personal story submitted to SPA, Submission 042***

The immediate and far-reaching effects of suicide are therefore undeniable. However, while suicide rates may provide some indication as to the extent of the problem, they only tell part of the story.

i. The human cost of suicide and suicide attempts

Evidence suggests the personal and social costs of suicide in Australia are significant. Personal stories received by SPA from members and the public repeatedly demonstrated the enormous toll suicide may take on many people's physical and mental health and wellbeing, and sense of self. Suicide attempt survivors and those bereaved by suicide, in particular, recounted experiences of financial stress as a result of loss of employment, an inability to return to work or the financial imperative to do so before they were ready. Estrangement from social networks, relationship breakdown, impediments to educational progress and study, family conflict (particularly relevant to ethnicity and cultural beliefs about suicide) and changes to religious or spiritual beliefs (producing personal discord in some instances and comfort in others) were just some of the other personal impacts of suicide expressed by contributors.

> *"My son had to put aside his grief and complete the HSC under tremendous pressure. We also had to fill out lots of forms for special consideration, apply for scholarships, apply for financial assistance for University education – all under time pressure and when we were emotionally struggling".*
>
> ***-- Personal story submitted to SPA, Submission 038***

> *"Spiritually there has been a change. I think about this a great deal more. Having not been a church goer at all…I was surprised that when XX [daughter] died I was very adamant that I wanted a religious service…now I attend church quite regularly…[I] find church a quiet reflective place".*
>
> ***-- Personal story submitted to SPA, Submission 063***

> *"I am currently 24, but made my first suicide attempt was when I was 14, then my second when I was 15…[suicide] is very taboo, particularly in ethnic cultures…my Grandfather says that people who commit suicide will burn in hell!"*
>
> ***-- Personal story submitted to SPA, Submission 021***

"I have attempted suicide four times; three times in 2006, the most recent in August 2009…I have been off work for six months, so my financial situation has become quite serious. All my savings have been used up in living expenses. I am receiving sickness benefits, but it does not even cover my mortgage and utilities let alone anything else…If I can't get back to work in a few weeks, I am looking at losing my home".

-- Personal story submitted to SPA, Submission 005

"I had little choice but to return to work after exhausting my holiday and sick leave, some nine weeks in total. It was not the right choice for my mood, my esteem, my ability to cope with the changes being placed on me…but there was no alternative".

-- Personal story submitted to SPA, Submission 006

"My sense of self was destroyed by my suicide attempt".

-- Personal story submitted to SPA, Submission 018

Both suicide and suicide attempts can cause not only immense distress to individuals, but also vicarious trauma among the wider community. Individuals in workplaces, for example, often witness and experience the impact of a suicide and are typically left at a loss to know how to help. The impact of a suicide attempt on first responders, such as police, ambulance and fire brigade, should also not be underestimated.

In rural and remote Aboriginal areas, suicide deaths often spark clusters of suicides (Hunter et al., 2001). Suicide deaths, particularly by hanging, are frequently witnessed by many members of an Indigenous community. In some instances, high levels of exposure to both death and suicide have resulted in a de-sensitisation among members of Indigenous communities, where "suicide and self-harm behaviour becomes normal, and even expected (though by no means acceptable)" (Farrelly, 2008).

These situations can often lead to the mounting problem of intergenerational transmissions of trauma and grief, and may result in the overuse of drugs and alcohol, incarceration, self-harm, seemingly reckless self-destructive behaviours and, in some cases, suicide.

"Being an Aboriginal woman, I have seen many, many suicides, and Aboriginal people are affected by all of them; such is the nature of the family connections. Aboriginal people are in ongoing grief from the early deaths of their youths".

-- Personal story submitted to SPA, Submission 037

Such examples clearly demonstrate the need for suicide prevention strategies to address risk at the community level, rather than just that of the individual.

[Please note: The SPA Position Statement, 'Suicide Prevention and Capacity Building in Australian Indigenous Communities', covers these issues in greater detail].

The resulting legacies of wide-ranging emotional responses to suicide (not restricted to grief alone, but also inclusive of shame, sorrow, fear, rejection, anger and guilt) transcend the immediate loss. These responses frequently result in secondary losses for many individuals (for example, loss of confidence and self-esteem; loss of trust in their relationship with the deceased; and loss of social support networks and friends who may not be able to cope).

"I was very lucky to have a few very supportive friends…Without them I don't know how I would have got through it. My other friends were also very supportive at first. I was very open to talking to them about it and trying to help them to understand, which helped them a lot. After still struggling with depression after some time, many friends eventually grew tired of it and began to become more distant and grow apart from me. Other people were not so supportive. Some people refused to acknowledge what had happened, some avoiding me, others simply pretending nothing was different. At the other extreme some, a rare few, but some nonetheless, blatantly told me that they wanted nothing to do with me…This response was the most devastating of all; to have lost so much and then have your friends turn away from you in disgrace is absolutely humiliating and devastating…"

-- Personal story submitted to SPA, Submission 018

The responses to suicide are further complicated by societal perceptions of the act of suicide as a failure on the part of either the deceased (to cope) or the family (for not having intervened or prevented the suicide). The complexities of the emotional relationship with the deceased prior to death can also compound the ability to cope among those bereaved by suicide, particularly in families where the deceased had a prior mental illness (Rubel, 1999). Blame for the loss is often ascribed on the bereaved who may therefore be viewed more negatively by themselves and/or by others (Jordan, 2001).

"When I tell people dad took his life there is a great stigma, and [I am] looked at as [if] to ask, 'well what did you do to contribute?'"

-- Personal story submitted to SPA, Submission 035

This stigma towards suicide (individual and societal) introduces a unique stress on the bereavement process and also on the recovery process for suicide attempt survivors. The feelings of intense shame and rejection often experienced by suicide attempt survivors and those bereaved by suicide can diminish an individual's ability to interact socially; thereby also significantly altering personal relationships (sometimes to the point of family conflict and/or disintegration) and relationships with surrounding social structures (Worden, 1991; Cvinar, 2005; Doka, 2002).

"There are some work 'colleagues' who seem to have chosen to totally ignore or acknowledge the circumstances and predicament I found myself in. Most allow friendships to be non-existent, lacking in understanding, no amount of compassion shown. Oblivious to your distress, not realising the negative impact they are having upon yourself and, to some extent, a path to recovery. And given these colleagues are health professionals, I find this thoroughly disheartening".

-- Personal story submitted to SPA, Submission 006

"I find it extremely hard to get attached to people. I'm very closed off emotionally. A lot of my relationships have ended as I couldn't talk to people, didn't want to know people. I'm scared of being left again and find that if I leave them I am making the choice and preventing too much hurt".

-- Personal story submitted to SPA, Submission 073

These circumstances can lead to increased, or in some cases, complete, isolation of individuals, and those caring for them, during the period immediately following the suicide or suicide attempt. Similarly, suicide bereavement can result in complications other than the personal deterioration of mental and physical health. These can include financial problems, the prospect of unemployment, an increasing sense of hopelessness and, at worst, increased suicide risk (Worden, 1991; Cvinar, 2005; Mitchell et al., 2005; Krysinska, 2003; Szanto, Prigerson, & Reynolds, 2001).

"He [brother-in-law] and my brother went away for the weekend and unfortunately XX [brother-in-law] hung himself while my brother slept. My brother is an alcoholic already struggling with his own life choices. I thought for a while this may have been a way of helping him, but unfortunately that ripple effect continues. Now he is talking of suicide. What do we do? If we couldn't stop XX [brother-in-law] and the counsellors couldn't, then how are we going to stop our brother?"

-- Personal story submitted to SPA, Submission 046

"Since I have suffered with major depression my whole life, I now realise I have limited my social and employment opportunities. I find I have little confidence and have been reluctant to commit to anything in case I am not well and cannot do what I have said I would. Consequently, I have very few friends…I am very unclear about my sense of self and purpose at the moment. I am constantly concerned that I will become sick again in the future even if I recover this time. I feel I can't rebuild my life knowing that I will get sick again in a couple of years. As I feel I have no emotional support in my private life or appreciation in my professional life, I don't know what my purpose is".

-- Personal story submitted to SPA, Submission 005

"I was not in a good state of mind at all and wished that he [husband] had taken me with him. I thought about suicide on a few occasions…I was extremely lost and absolutely everything in my life changed within three months of XX [husband] passing away. I replaced some of my emotions with food and gained 25kg in a very short time. I was unhappy with every aspect of my life…"

-- Personal story submitted to SPA, Submission 073

Empirical and clinical evidence suggests that individuals bereaved by suicide are more likely to experience suicidal ideation and behaviours than others not exposed to loss by suicide (Crosby & Sacks, 2002; Cleiren & Diekstra, 1995; Sands, 2008; Jordan, 2001). Imitative suicides have previously been noted in the literature on suicide bereavement, particularly among adolescents and young adults (Krysinska, 2003; Stack, 2000; Velting & Gould, 1997).

Bereaved families also face particular dilemmas, such as what to tell others and the intrusions by police and legal processes surrounding 'sudden death'. The question, "Why did he/she do it?", also often becomes a haunting and "compelling quest" (Clark, 2001, p. 102).

"My husband answered the door to three male police officers, none of whom had been to our house earlier. They explained that they wanted the key to XX's [son] room to inspect it. We guessed the reason was to see if a suicide note had been left…The three police officers had entered our house uninvited…Their attitude was disrespectful and arrogant!!"

-- Personal story submitted to SPA, Submission 027

"My granddad committed suicide about five years before I was born. Although I never met him, the pain it has caused my family is visible and, surprisingly, it made me more determined to understand why he would have left his whole family and life behind him. I believe that you are always left with the wanting to know WHY and this is what drives me to want to help people prevent suicide".

-- Personal story submitted to SPA, Submission 056

The personal and social costs for suicide attempt survivors are also significantly profound and debilitating, particularly with regards to human rights issues. Evidence alarmingly shows that those who have survived a suicide attempt are sometimes involuntarily detained and may also receive various (often physical) treatments, often without legal representation or their own input to the decision-making process. Although, admittedly, there is currently little information on the long-term impact of involuntary treatment on suicide attempt survivors, the absence of lawyers means a loss of freedom that ultimately undermines Australia's commitment to human rights (Walters, 2009). When individuals are scheduled and/or detained for their own protection, all decisions need to be taken based on the basic principles of human rights and suicide attempt survivors should be given a 'voice', where possible, in their own treatment.

"There seems to be a rubber stamping attitude to psychiatry in the public system, rather than individually assessing each situation and applying relevant Mental Health Act provisions. For example, on my most recent admission to the acute psychiatric ward, the psychiatrist, who I had not seen before, said that he would admit me involuntarily. I did not fulfil the requirements of the Mental Health Act to be admitted involuntarily… The nurses present appeared to be just as surprised as I was. It was also apparent that this doctor had not read my file when he was thinking about treating me with ECT. If he had read my file he would have known that I had a very long course of ECT in 2006 which did not work. I am also concerned that while I was admitted as a voluntary patient, I was told that if I left the ward on my own I would be made involuntary. This has happened to me each time I was admitted…A patient either satisfies the five requirements for involuntary status or not. It seems that the concept of the patient's ability to consent to treatment is rather fluid in the eyes of psychiatrists".

-- Personal story submitted to SPA, Submission 005

ii. The economic costs of suicide in Australia

Beyond the human suffering and emotional and social toll, there are also financial costs associated with suicide and suicide attempt in Australia, although presently there are no reliable national estimates available. There are state-based exceptions to this. On this point, SPA refers the Committee to the following report, which SPA acknowledges may now be considered dated in terms of its timeliness of publication:

- Watson, W. L., & Ozanne-Smith, J. (1997). *The cost of injury to Victoria*. Report No. 124. Accident Research Centre, Monash University. Available online: http://www.monash.edu.au/muarc/reports/muarc124.pdf

Other reports have provided estimates of the economic cost of suicide in relation to specific mental disorders. For example, a previous Access Economics report for SANE Australia (2002) indicates that the direct and indirect costs of schizophrenia and associated suicides are enormous. In 2001, for example, real financial costs of illness totalled $1.85 billion, about 0.3% of GDP and nearly $50,000 on average for each of more than 37,000 Australians with the illness (Access Economics; SANE Australia, 2002).

The direct and indirect costs of bipolar disorder and associated suicides are also substantial. In 2003, for example, real financial costs totalled $1.59 billion, 0.2% of GDP and over $16,000 on average for each of nearly 100,000 Australians with the illness. Moreover, the burden of disease – the pain, suffering, disability and death – associated with bipolar disorder is greater than that of ovarian cancer, rheumatoid arthritis or HIV/AIDs, and similar to schizophrenia and melanoma; resulting in 4,843 years lost due to suicide and self-harm (Access Economics; SANE Australia, 2003).

Quantitative data is also available on the national injury burden or burden of disease in Australia, which is notably dominated by suicide and self-inflicted injuries, road traffic accidents and accidental falls (Cripps & Harrison, 2008; Begg et al., 2007). However, it has frequently been remarked in health economics literature that the compilation of costs of illness or burden of disease estimates (typically measured by the metric of 'disability adjusted life years') is not necessarily a useful exercise for policy-making purposes. "Policy-makers need proposals for specific interventions, which can then be assessed in terms of their expected benefits and costs, relative to alternative interventions or to 'doing nothing'" (O'Dea & Tucker, 2005, p. 3).

Others, such as Yang & Lester (2007), have suggested that net cost estimates of suicide should go beyond accounting for direct medical costs and indirect costs from loss of earnings of those who suicide. Yang & Lester (2007) also suggest that the premature death resulting from suicide may actually derive savings to society from the avoidance of having to treat the depressive and other psychiatric disorders of those who suicide; avoidance of pension, social security and nursing home care costs; and assisted suicide.

This conclusion does not imply, however, that suicide should be acceptable to society (Yang & Lester, 2007). Nor does it estimate the costs to productivity and performance, for example, of survivors of suicide and the bereaved, and the deleterious personal and societal effects that may well increase the use of support services and medical care for these individuals (Stack, 2007).

SPA would strongly argue that successful suicide prevention strategies and crisis interventions may generate significant economic returns in their own right, given that the economic benefits of a suicide prevention strategy are the gains to society as measured by the economic value of the lives that would be saved as a result of such a strategy (Kennelly, 2007). SPA therefore believes estimates of the economic cost of suicide can be useful in that these provide some idea of the conditions and the populations for which the burden of disease is greatest, and can therefore provide guidance as to where research on developing new interventions might be best focused to give greatest potential gain. Detailed estimates of cost components can also provide useful input to a cost-effectiveness analysis of a proposed specific intervention and its subsequent evaluation (O'Dea & Tucker, 2005).

It is for this reason that SPA strongly endorses the need for increased funding towards research into not only the economic costs of suicide and suicide attempts in Australia, but more comprehensively, the economic costs associated with the complex trajectory of suicidality – from prevention to intervention and postvention. This research might consider exploring overseas costing models (discussed in greater detail below) for guidance on how best to approach the development of economic estimates around suicide in Australia, and the ethical dimensions associated with these models.

It is also proposed that this research more specifically include a mapping exercise, which SPA would be willing to undertake with the appropriate funding and resourcing, to collect, by postcode, Australian Bureau of Statistics/National Coronial Information Service (ABS/NCIS) data on suicides in addition to self-harm and service provision data (e.g. calls to helplines and traffic to eHealth programs and services such as those of *Reach Out* and *headspace*) to assist in advocating funding priorities determined by geographic need rather than those based simply on competitive tendering (which some researchers have claimed has a tendency to discourage collaboration within the sector and between researchers, agencies and service providers; see further discussion below).

iii. International literature and potential costing models

Despite the limited estimates and detailed research on the economic costs of suicide in Australia, some excellent material, somewhat comparable to the Australian cultural context, is available internationally, from jurisdictions including California, Ireland and New Zealand.

International studies of the cost of suicide can be broadly summarised as adopting the following methods which may or may not function as a useful guide to proposed Australian measures:

- The **use of a human capital approach** to valuing lost life years, rather than a willingness-to-pay approach.
- The **extension of the human capital approach** to valuing the lost life years even for those years in which the person would not be in paid employment – for instance, for those years past the age of retirement (usually assumed to be 65 years), or for the ages 15 to 64 when not actually in paid employment. This brings up the question of the value of **time not in paid employment**.
- The **use of a cut-off** of 75 years of age, beyond which lost years of life are not counted.
- The **discount rate** used for discounting future earnings or life years.

Further detail regarding suggested or potential methods/approaches to estimating the cost of suicide can be found in the source of the above summary, which SPA refers to the Committee for review:

- O'Dea, D., & Tucker, S. (2005). *The Cost of Suicide to Society*. Wellington, New Zealand: Ministry of Health.

This study estimated that, in 2002, the total cost of suicide in New Zealand was around $1.4 billion, incorporating both economic costs (i.e. services used in cases of suicide and attempted suicide, and lost production from exit or absence from the workforce) and non-economic costs (i.e. lost years of disability-free life and grief of family and friends). To put this in perspective, at the time of the study, figures suggested that around 500 deaths in New Zealand were attributable to suicide annually. This was roughly comparable to the number of deaths in road accidents in the country each year. A substantial additional number of individuals were found to self-harm or have attempted suicide (O'Dea & Tucker, 2005).

Obviously, it is important to remember in a study of this kind that the economic burden of suicide is spread throughout a number of systems, not least of all, employment, education, primary care, hospitals, mental health and criminal justice. Analysis of costs by system would show cross-systemic variations. Costs will also vary by social group – for example, the costs of Indigenous suicide might be estimated very differently to non-Indigenous suicide, especially when one considers cultural impacts and impacts on whole communities.

The appropriateness of adding together such different cost concepts (i.e. economic costs relative to personal and social costs) warrants some attention also; suggesting that a more appropriate approach may be to measure economic and non-economic costs separately (O'Dea & Tucker, 2005). Quantitative and qualitative components will both be important, and top-down approaches need to be complemented by grassroots, bottom-up and alternative economic approaches, such as those advocated by Nobel laureate, Amartya Sen.

The choice of costing model remains largely dependent on the object of measurement, though the available instruments to measure the concept of 'social loss' (i.e. the losses to all people in a community as a result of suicide) are imperfect. It is difficult to attribute a monetary value to the human costs of suicide, such as the 'burden of grief' associated with such deaths. More to the point, it is also obviously difficult to put a value on life itself. Doing so in either case may raise ethical concerns or issues of perceived insensitivity in attempting to place a monetary value on the costs of suicide mortality.

Some authors (see Doessel et al., 2009 for example) have argued the case for potential years of life lost (PYLL) as a more suitable measure when detecting the social impact of suicide and societal suicide interventions, as compared to a simple count of deaths or any measure based on it (such as the suicide rate). However, studies focusing on PYLL do not typically account for various factors that might affect mortality trends (e.g. the efficacy and impact of specific suicide prevention strategies or population-level risk factors for suicide). Rather, the PYLL approach seeks to measure

the importance (i.e. magnitude) of suicide relative to other causes of death; incorporating the notion that one death is not implicitly the same as another (Doessel et al., 2009).

The dangers of such a position in this context are that it is uncomfortably close to seeing human value in terms of social productivity. It leads directly to the conclusion that some lives are more important than others. The potential outcomes are that older people's lives, for example, may be devalued in comparison to the lives of younger people. This raises ethical questions of whether suicide in an older person is any less important than that of a younger person.

These broader issues and ethical concerns highlight "the need to pay careful attention to the values upon which assumptions of measurement…are based" (Doessel et al., 2009, p. 7). Such considerations should be made in relation to costing models developed for the Australian context, as should the fact that economic cost estimates remain contingent on the quality and integrity of suicide data. These factors warrant further debate.

[For more on this final point, see SPA's response to TOR b)].

RECOMMENDATIONS – TOR a)

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. Resourcing for the completion of a mapping exercise to collect, by postcode, ABS/NCIS and service provision data on suicide and self-harm in Australia to advocate for funding priorities determined by geographic need.

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

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 those at risk)

In Australia, as in other international jurisdictions, suicide rates are widely used as a progress indicator. Much depends on the accuracy of reported suicide trends; not least of all, appropriately targeted prevention strategies and research, economic costings of suicide *[see SPA's response to TOR a)]*, project funding including that of support services, and campaigns to combat the social stigma associated with suicide. Reliable statistical information is therefore vital, although there has been much debate worldwide about the accuracy of official national suicide figures.

Currently, the main source of suicide data in Australia is the Australian Bureau of Statistics (ABS). Cautionary notes in recent editions of ABS reports on causes of death, and other information, have prompted concerns that official statistics on suicide in Australia might be underestimated (Harrison, Pointer, & Elnour, 2009).

Findings from the concept paper, *Let's Get Serious: The Infrastructure to Effectively Address Suicide in Australia* (2009), prepared by ConNetica Consulting for the Suicide Prevention Taskforce and SPA, propose that suicide rates are significantly under-reported with evidence to suggest that the rate of under-reporting is increasing. Preliminary analyses of the National Coronial Information Service (NCIS), for example, show close to 30% under-reporting of suicides when compared with ABS data. This does not factor in the significant increase in single vehicle road deaths in recent years, which now account for almost 50% of all road fatalities in Australia (ConNetica Consulting for the Suicide Prevention Taskforce and SPA, 2009).

The ABS has cautioned that care should be taken in the interpretation of the suicide statistics it releases as there are "indications that the reported downward trend in suicide deaths in recent years may be, at least in part, due to an increase in the number of open coroners' cases when the ABS finalises its annual suicide statistics" (Harrison, Pointer, & Elnour, 2009, p. 1). The extent to which the decline, particularly in young male suicide (20 to 34 years) in Australia since 1998, is attributable to the misclassification of cause of death information has been questioned (see Page, Taylor & Martin, submitted), although trends in the opposite direction for certain other ICD-10 code ranges raise the possibility of increased misclassification, especially after 2002 (Harrison, Pointer, & Elnour, 2009).

How much of the downward trend in deaths registered as suicides since 1998 is due to a real decline in the number of suicide deaths as opposed to under-enumeration or misclassification is therefore not immediately apparent, nor the full extent of the problem of under-reporting known (Harrison, Pointer, & Elnour, 2009). However, the acknowledgement of potential undercounting could be said to have undermined the apparently sharply declining rates of suicide reported by the ABS over the past decade (De Leo et al., National Committee for Standardised Reporting on Suicide, 2009).

Aside from the numerical basis on which much of this debate rests, it is anecdotally evident that the social stigma associated with suicide and self-harm continues to dissuade full disclosure and reporting of deaths as suicide (De Leo et al., National Committee for Standardised Reporting on Suicide, 2009), as well as help-seeking among vulnerable individuals and public discussions of the impact of suicide and self-harm on the Australian community.

[Please note: more on this can be found in the introductory section of this submission].

i. Impediments to the accuracy of reported suicide trends

In an attempt to address the problem of under-reporting, the ABS has indicated that it will revise data beginning with all deaths registered in 2007, though delayed case closure is expected to prevent final counts (and full benefit) for several years. Newly-adopted ABS coding practices may also require evaluation.

Different to undercounting, but potentially just as significant a contributor to a deficiency in awareness of suicide risk factors and distribution, is the lack of information in death records on some characteristics of people dying by suicide (De Leo et al., National Committee for Standardised Reporting on Suicide, 2009). For example, evidence shows that Indigenous Australians aged 12 to 24 years have suicide rates four times higher than comparable non-Indigenous Australians. However, frequent under-identification of Indigenous status at death hampers measurement and analysis in this area. Similarly, gay, lesbian, bisexual and transgender status is also seldom recorded, despite the over-representation of these groups in suicide and self-harm statistics (De Leo et al., National Committee for Standardised Reporting on Suicide, 2009).

More comprehensive primary data on the risk/demographic indicators of suicide – not just a determination of suicide – from a range of sources (e.g. police reports, forensic pathologists, coronial findings, psychological autopsies) may, in fact, prove beneficial to strengthening the consistency and accuracy of suicide statistics and the subsequent analysis of this data for research purposes and preventive strategies.

Part of the current problem is attributable to the fact that, in Australia, suicide statistics depend on a complex process of information capture, distribution and processing that involves numerous organisations and individuals. No one body or portfolio is responsible for producing mortality data. Multiple parties collect data for different, sometimes disparate, purposes (e.g. legal, statistical, research-oriented) with different standards of proof and reporting timelines (Harrison, Pointer, & Elnour, 2009; De Leo et al., National Committee for Standardised Reporting on Suicide, 2009).

The terminology related to suicide and self-harm also varies greatly across jurisdictions and among coroners who are ultimately responsible for the determination of death (and intent).

SPA acknowledges that, in recent years, reforms have occurred within the coronial system in Australia and, similarly, that – despite their disparities in approach – organisations responsible for data collection and coding practices, such as that conducted through the NCIS, have in place their own internal quality assurance procedures and systems (Harrison, Pointer, & Elnour, 2009). A number of remaining inherent barriers (e.g. political, legal/jurisdictional, philosophical, and practical) must be addressed if progress on the integrity and timeliness of suicide and suicide-related data in Australia is to be made.

The literature shows these impediments include, but are by no means limited to:

- Absence of a central authority for mortality data production;
- Lack of standardised reporting, collection and capture, classification and coding procedures across Australian jurisdictions;
- Lack of systemic resourcing, training and shared expertise;
- Concerns over validation of data and the impact of legacy issues associated with data collection processes and reporting procedures that have since been superseded;
- Burden of proof for coroners making a positive finding of suicide differs from the statistical requirements for research/policy purposes;
- Retrospectively-commissioned research to revise suicide numbers (which, while commendable in principle, will delay final counts and full benefit by several years);
- Deficiencies in the standardised identification of characteristics on death records related to Indigenous status and gay, lesbian, bisexual and transgender people;
- Life insurance 13-month exemptions for suicide, which are currently commonplace, and require industry reform;
- Traditional lack of coordination and collaboration between coroners, forensic counselling services, and those bereaved by suicide to identify, understand and respond to situations where suicide determinations are at variance with a family's wishes; and
- Social stigma associated with suicide and mental illness is a constant deterrent to accurate reporting.

Statistics also show that, in Australia, the rate of completed suicide is higher for men than women, although more women than men attempt suicide (Australian Bureau of Statistics, 2009). The higher likelihood in men to choose more lethal means of death or methods of suicide that result in instant death (e.g. use of firearms) relative to women may well complicate coronial determinations of suicide as cause of death among women, and impact on the accuracy of statistics underpinning the reported prevalence of female suicide in Australia. This is because, for some mechanisms of death where it may be very difficult to determine suicidal intent (e.g. drowning, poisoning by drugs), the burden of proof required for the coroner to establish that the death was suicide may make a finding of suicide less likely (Australian Bureau of Statistics, 2009).

A more comprehensive summary of the deficiencies related to suicide statistics and the methods of data collection used in Australia can be found in the following recent reports to which SPA refers the Committee for further reading and review:

- Henley, G., & Harrison, J. E. (2009). *Injury Deaths, Australia 2004-05*. AIHW Injury Research and Statistics Series No. 51. (Cat. No. INJCAT 127). Adelaide: AIHW.
  Available online: http://www.nisu.flinders.edu.au/pubs/reports/2009/injcat127.pdf
- Harrison, J. E., Pointer, S., & Elnour, A. A. (2009). *A review of suicide statistics in Australia*. AIHW Injury Research and Statistics Series No. 49. (Cat. No. INJCAT 121). Adelaide: AIHW.
  Available online: http://www.aihw.gov.au/publications/inj/injcat-121-10754/injcat-121-10754.pdf

ii. National Committee for Standardised Reporting on Suicide

Given the need to respond to and address the aforementioned impediments, coupled with growing advocacy around the necessity for accurate suicide statistics in Australia, a coordinated and widely consultative approach is essential. Standardised reporting of suicide has also previously been identified as a principal objective/outcome of the Federal Government's *National Suicide Prevention Strategy*.

A national committee whose membership canvasses the diversity of stakeholders requisite to addressing the problem of under-reporting of suicide in Australia could provide the necessary oversight and collaborative direction for such an initiative. With this in mind, in 2008, SPA commenced a consultative process aimed at exploring the pragmatics of achieving improved and standardised reporting of suicide and self-harm in Australia. As part of this project, SPA consulted broadly on the issue with NCIS, key researchers, regional projects between local coroners and services, various health and community services, and representatives from the Child Death Review Committee (NSW) and

Victorian Institute of Forensic Medicine. It was this process that led us to believe a National Committee for Standardised Reporting on Suicide (NCSRS) needed to be established.

With representatives from ABS, NCIS, Australian Institute for Suicide Research and Prevention (AISRAP), Australian Institute of Health and Welfare (AIHW), Australian Suicide Prevention Advisory Council (ASPAC), Australian Government's Department of Health and Ageing (DoHA), police, coroners, funeral directors and university researchers, among others, the key objective of the NCSRS is to help coordinate the various stakeholders (and projects) within the system to appropriately address the challenges associated with developing a standardised and collaborative approach to suicide recording and reporting. The collective has so far met on two separate occasions and has already identified a number of priorities for systemic reform, as well as a provisional implementation strategy.

[Please note: SPA would strongly encourage the Committee to refer for further detail to the recommendations presented by the NCSRS in its separate submission to the Senate Inquiry].

SPA has been in a unique position to establish the NCSRS; drawing on its status as a broad-based organisation that brings together diverse interests across disciplines, practitioners, researchers, and those in the community affected by suicide and self-harm. This approach to advocacy within the suicide prevention sector has enabled SPA to draw together a cross-jurisdictional collective to secure multi-party agreement on adequate, standard and operationalised criteria and reporting formats for suicide and related data, as well as collaboration across the range of stakeholders and projects addressing this issue in the push towards systemic reform.

Resource implications, accountability, and consultation and information processes for the NCSRS require clarification. Significant potential to overcome these issues exists, however, given the goodwill the initiative has already attracted (apparent in the convening of the NCSRS itself) and appropriate resource allocation (De Leo et al., National Committee for Standardised Reporting of Suicide, 2009).

RECOMMENDATIONS – TOR b)

1. Standardised reporting, collection and capture, classification and coding of suicide-related data across Australian jurisdictions.
2. Commission research to assess the resource and training implications of enhanced data collection and coding requirements for data stakeholders, assessing the potentially competing priorities of completeness, reliability and rapidity.
3. Conduct an evaluation of newly-adopted ABS coding practices.
4. There is a need for clearer portfolio responsibilities and resources for the mortality system in Australia, including the establishment of a central authority for mortality data production.
5. Ensure comprehensive and standardised primary data on risk/demographic indicators, including identification of sexual orientation, gender identity and Indigenous suicides in the collection of data for purposes such as coronial records and reports prepared by police to assist coroners.
6. Ensure consistent implementation of the use of the national standard Form 13 by police throughout all jurisdictions in Australia.
7. Improve cross-jurisdictional communications and access to medical records.
8. Ensure appointment, education and training of qualified and dedicated NCIS coders and police inquiry officers, with particular skills and/or familiarity in mental health and drug and alcohol.
9. With leadership from Chief Coroners in each jurisdiction, improve consistency in coronial processes with regards to reporting on intent, including legislative clarity around the issue, consistency of terminology, and the possible introduction of graded coronial determinations of the likelihood of suicide and/or intent.
10. Undertake collaborative work with coroners, forensic counselling services and those recently bereaved by suicide, to identify and examine those situations where suicide determinations may be at variance with families' wishes.
11. Commission research to elucidate what aspects of the recent decline in Australian suicide statistics are due to real changes and which are due to artefact.

The aims of the National Committee for Standardised Reporting on Suicide (NCSRS) are as follows:

1. To achieve cross-jurisdictional and multi-party agreement on adequate, standard and operationalised criteria and reporting formats for suicide and related data.
2. To work collaboratively across the range of stakeholders and projects addressing this issue towards systemic reform.
3. To identify gaps and priorities for the development of complementary projects to further the broad agenda of standardised reporting on suicide.
4. To establish working groups and pilot projects to implement these projects.
5. To collaboratively develop recommendations for changes within various components of the system as well as at a systemic level.
6. To identify resource implications of any proposed reform.
7. To develop a proposed implementation strategy to pilot and then implement national reform in standardised reporting on suicide.

c) The appropriate role and effectiveness of agencies, such as police, emergency departments, law enforcement and general health services in assisting people at risk of suicide

SPA acknowledges the agencies towards which response is directed by the Committee in the above TOR. However, we would ask the Committee to consider an expansion of this list to include what we perceive to be other relevant agencies for consideration, including coronial services, the criminal justice system, and what are more generally referred to as 'first responders' (i.e. police, ambulance officers and fire brigade) to suicide and suicide attempts. We have also taken the liberty of addressing the appropriateness and effectiveness of care settings associated with these primary agencies for people at risk of suicide and self-harm.

Currently, in Australia, there is limited information about first responders; who they are, what their training is, and what impact their behaviours can have on future help-seeking, although, from anecdotal evidence, there is some suggestion that the presence of police during a suicidal crisis, for example, may be problematic for those experiencing the crisis. There is clearly a need to better understand the work of teams that first respond to situations involving suicide, self-harm or suicidal crisis/attempted suicide. More imperatively, there are questions to be asked as to what agencies are most appropriately placed to act as first responders to these situations.

Responses to previous stakeholder and community consultations undertaken by SPA suggest that police and coronial investigations following a possible suicide can often compound the pain of those bereaved by the death, especially in cases where individuals and/or families have had previously traumatic experiences within the criminal justice system. For these individuals and families, police and coronial investigations can contribute to an added independent and heightened sense of anxiety.

This is also true of cases where there is uncertainty as to whether the cause of death is suicide or homicide (Rubel, 1999). In these situations, official procedures necessitated by a possible suicide or homicide investigation require bereaved individuals to respond to questioning from police. While this is understandable, given standard police procedures and the fact that the location of a suicide is often, first and foremost, deemed a 'crime scene' by investigators, the nature of police interviews and investigations does not make the process any less emotional for bereaved individuals. In fact, there is evidence to suggest from the responses SPA has received as part of its community consultations that stigma can sometimes be perpetuated through and by the processes of police and coronial investigations.

Such procedures (both police and coronial) can often be perceived as insensitive and distressing (particularly police first contact within Indigenous communities and the 'concealment' of suicide from families). This can exacerbate feelings of hopelessness and guilt among the bereaved, while also potentially prolonging the time for individuals, families and communities to finalise funeral arrangements and to undertake personal and private rituals and acts of memorialisation – all of which have previously been shown to help normalise the grieving process (Barlow & Morrison, 2002; Burnell & Burnell, 1989).

> *"The coroner's office was very, very slow. Mistakes were made with the death certificate, with details of his [brother] death and with reissues of the death certificate. This caused my parents a huge amount of additional distress at a time they were barely able to keep afloat… The police made simple and silly mistakes in their reports regarding details that changed the context and circumstances of the death, which in turn affected the coroner's interpretation of events. This in turn had roll on effects by making the management of his [brother] estate a long and protracted affair, which again caused my parents great additional trauma and seemed to accentuate their grief".*
>
> ***-- Personal story submitted to SPA, Submission 055***

> *"Overall, they were quite good – ambulance, police, coroner. However, I did feel upset when I had to go down to the police station to make a statement about a week after my husband's death. The police officer had been at my house on the night and knew what had happened, but kept asking me what happened, even to the point of me having to tell her what she did! This was clearly the first time she had taken a statement and definitely needed more training".*
>
> ***-- Personal story submitted to SPA, Submission 038***

Conversely, research suggests that if first responders act with compassion and empathy towards bereaved individuals and suicide attempt survivors, this can make a difference in and to their recovery (Suicide Prevention Resource Center, 2005). This was alluded to in some of the personal stories received by SPA.

> *"The police on the day were brilliant, especially the police woman. She was wonderful and, as the day is a blur with some of the details of what they did, I just know she spoke with compassion and understanding. Plus, they came to my home two times, firstly to return my brother's personal items on him at the time. The coroner contacts were also very good at the time".*
>
> ***-- Personal story submitted to SPA, Submission 049***

> *"Police need to give phone numbers to loved ones at the time of interviewing, photographing etc. This will help loved ones get the help from the start and not feel isolated and take their lives. They then can support the individual family's needs. Funeral places also need the numbers of support services to offer the loved ones".*
>
> ***-- Personal story submitted to SPA, Submission 035***

In Australia, many coronial counsellors offer personal support to suicide bereaved individuals. There is some speculation still as to whether the response and support mechanisms of coronial services are standardised across jurisdictions. While this would suggest that greater compassion and sensitivity needs to be incorporated into the training and procedures of first responders and coronial staff, as well as their interactions with bereaved individuals, families, and suicide attempt survivors, SPA believes this must be done in conjunction with greater recognition of the post-traumatic effects and vicarious trauma experienced *by these same professionals* as a consequence of their continuing exposure to and involvement with deaths resulting from suicide and self-harm.

i. The vicarious effects of suicide and self-harm related trauma on professionals

The vicarious trauma and impact of suicide (particularly where the deceased was a patient or client) on first responders, clinicians, general practitioners and other health professionals (including coronial staff), and also volunteers, work colleagues and whole communities more broadly, should not be underestimated. First responders – police, in particular – have previously recounted their experiences of attending incidents related to suicide and self-harm for which no amount of training could have prepared them. At SPA's 2009 World Suicide Prevention Day (WSPD) Community Forum, for example, Western Australian Police Deputy Commissioner, Chris Dawson, recalled finding the child of a man who had just taken his own life:

> *"She was about four years of age…I found her crouched in the corner of the room and I hoped she hadn't seen what I'd seen. I'll never know. I don't want to over-dramatise it, but it is the reality".*
>
> ***-- Western Australian Police Deputy Commissioner, Chris Dawson***

Clinicians and other professionals responsible for the care of the deceased prior to death are not immune either from the effects of suicide bereavement (Myers & Fine, 2007). However, it is only recently that the personal issues faced by professionals after the suicide of a client or patient have been recognised as an area requiring greater attention, research and response (Clark, 2001; SANE Australia, 2009).

These individuals may well face the added personal conflict of having to deal with their own emotions – including a sense of loss and personal and professional failure – while at the same time being required to provide "objective support for the bereaved family, patients contemporary with the suicide victim and fellow team members" (Clark, 2001, p. 102). This is obviously further complicated in instances where a bereaved family feels aggrieved by a perceived failure of (mental) health care and treatment, which may increase a professional's fear for their reputation and of litigation (Hodgkinson, 1987; Michel et al., 1997).

"Professionally, dealing with a client who has suicidal or self-harm concerns is difficult because of the inherent anxiety about making sure you have fulfilled your duty of care, and acknowledging that no matter what you do, it may not be enough, and knowing that you may be blamed for not being able to do enough".

-- Personal story submitted to SPA, Submission 008

"In the north of Western Australia, there are not many services for Aboriginal people, period. Myself and my team were the service. We were hopelessly under-resourced to cover massive geographical regions, with no support for us in debriefing, time off…I suffered a form of breakdown after working up north in the area of suicide and child sexual abuse. I had to leave…and heal. I was physically ill for about a year after finishing work. My body was sick from one thing or another; it completely broke down. My marriage of 12 years fell apart also….I am very aware that I am still recovering emotionally, mentally and spiritually from my experiences".

-- Personal story submitted to SPA, Submission 037

Also not to be underestimated are the post-traumatic reactions often experienced by individuals (not always necessarily first responders) who either witness a suicide or discover the body after suicidal death; often likely with little social support or follow-up care and treatment after the event.

"We were the first on the scene of a suicide. The man in the next door holiday cabin hung himself. His wife discovered him. I tried to help the wife get the body down, but couldn't. I then had to go and get his children… and then explain to them that their father was dead. I then had to tend to my own children…I needed to drive past the 'suicide spot' every fortnight for a year. On the first four occasions, I had to stop the car and cry and yell and scream. I was so angry with that man. I relived the experience for months…I spent years thinking about the family – what were their names, did they cope, how are the little kids, of course why in the hell did he do it? Why was my family the one to be involved?"

"I would have appreciated a conversation with someone just to reassure me at the time that I did my best and that my best was okay. I was there to help the wife, the man's children, the lady proprietor, her child, my own children, but no-one reassured me or de-briefed with me… No one ever contacted me again after that weekend other than the police about four months later to say I was not needed at the coroner's court".

-- Personal story submitted to SPA, Submission 090

"I found XX [son] after going to his home when l could not contact him. This vision will be with me till the day l die, and never again will l be the same".

-- Personal story submitted to SPA, Submission 033

These issues will be covered in greater detail in the next SPA Position Statement, provisionally titled, *Emergency Services and Response*. This position statement is scheduled for completion in early 2010.

ii. Assistance for at-risk individuals in emergency department settings

There are currently limited options for those who are experiencing a suicidal crisis and are contemplating life or death. In Australia, when the suicidal crisis is particularly acute, hospitalisation may be necessary. Research suggests that the management of patients with deliberate self-harm largely occurs on an ad-hoc basis in Australian hospitals. The patient is commonly managed in the emergency department and not every patient receives formal psychiatric assessment (Whyte et al., 1997).

Anecdotal evidence indicates that emergency departments and hospital wards may not be the most appropriate settings for suicidal people and/or suicide attempt survivors, given they lack the space for the reflection needed to regain perspective and hope. *[This point is elaborated on in SPA's response to the role of targeted programs and services that address the particular circumstances of high risk groups in TOR f)].*

Suicide attempt survivors in emergency wards are a special group as they are not admitted for a particular illness or accident, but because of an act or action. Thus, interventions are required to address the psychological and emotional needs, as well as the physical consequences, of the act. However, doctors in emergency departments may focus solely on the physical aspects of treatment at the expense of a person's emotional distress (Hadfield, Brown, Pembroke, & Hayward, 2009). At-risk individuals may further benefit from improved widespread training of all emergency department staff in current suicide risk assessment protocols, as outlined by NSW Health's *Framework for Suicide Risk Assessment and Management* (2004), which has broader application in a number of health settings.

While many suicide attempt survivors have previously reported that they received appropriate care within the hospital environment, it is of concern that, in an Australian study, about one third of suicide attempt survivors reported their satisfaction with their hospital treatment as 'mixed' and one fifth as 'poor' or 'very poor'. Similar proportions were noted in relation to the attitude of health care professionals in the hospital environment, with 28 per cent of suicide attempt survivors describing the attitudes as 'mixed' and 33.5 per cent as 'poor' and 'very poor' (De Leo et al., 2005).

Similarly, the findings of an American study showed that the majority of suicide attempt survivors reported negative experiences in the emergency department. They felt that staff did not treat them with respect or listen to their version of events. Many also felt punished and stigmatised due to the suicide attempt (Cerel, Currier, & Conwell, 2006). These types of attitudes and punitive responses expressed by many health care professionals have major implications; one being the loss of contact with people who could otherwise be helped. Often, the ideas and prejudices surrounding suicide discourage people from talking about their suicidal thoughts (Tadros & Jolley, 2001).

"My experience with other [hospital] staff was just as bad. One nurse who had come to take my blood said little to me other than, 'is this your first time?' Later, I was taken to the cardiac ward and it was clear that the nurses were talking about me at the nurse's station. This was an utterly humiliating experience. It was over 24 hours before I was able to talk to anyone from a mental health team or anyone who was interested in anything other than the physical complications. I was also left in a room by myself with many cords and possible methods of suicide before my mental state had even been assessed. Essentially, this could have cost me my life if it had not been for the fact that I didn't happen to be suicidal by this point".

-- Personal story submitted to SPA, Submission 018

"The nurse informed me that I was both selfish and stupid to have done what I did and that her nephew had also done something similar that week and was equally selfish and stupid. I lied to every medical person who came to see me in order to get out of the hospital quicker. The experience I had in hospital meant I didn't go and see a GP for quite a few years".

-- Personal story submitted to SPA, Submission 004

"I found that ambulance workers, nurses and doctors (both from ER and ICU) were judgmental of me as if I had brought my sickness on myself and was wasting the resources available for deserving sick people".

-- Personal story submitted to SPA, Submission 005

"Some hospital staff are still under the impression that suicide and self harmers are attention seekers. This is far from the case, and needs to be recognised without prejudice".

-- Personal story submitted to SPA, Submission 002

However, patients in emergency departments do report that nurses and social workers are more helpful than physicians as a result of what is perceived to be better listening skills (Treloar & Pinfold, 1993). These results may reflect the difficulties of dealing with psychological issues in the busy environment of an emergency department. The Aeschi Working Group on

suicidal behaviours states that, "the current emergency room and clinic approaches to suicidal patients are too unempathic and unhelpful to succeed in drawing out patients' accounts of extreme pain and suffering in such a way so that the nature of their experience becomes clear, and a therapeutic alliance established" (Michel et al., 2009, p.1). Trusting relationships, including with professionals, are a prerequisite for the prevention of suicide (Michel et al., 2009; Alexander et al., 2009).

> *"After my suicide attempt I was linked up with acute community care team who would call me everyday to see how I was doing, I found this service ineffective as it was a different person who called every time, so I was unable to build the trusting relationship that is needed to share the intimate personal details of my life and tell them if I was experiencing trouble. Due to this, I would just tell them that I was fine and was no longer thinking about suicide or harming myself even when this was not true".*
>
> ***-- Personal story submitted to SPA, Submission 018***

iii. Assistance for mentally ill individuals in primary care settings

Primary care has previously been identified as an ideal setting in which to address the high comorbidity between mental and physical illnesses and disorders (Whiteford, 2008; Andrews, Slade, & Issakidis, 2002). However, international studies (for example, Hunt et al., 2006) show that:

> *Cases of suicide with drug dependence, alcohol dependence or personality disorder showed marked recent disengagement from services (e.g. missed appointments and self-discharge). Services were less likely to arrange follow-up appointments or attempt re-engagement with these patients. Services more often viewed suicide as preventable in schizophrenia, depression and bipolar disorder (p. 141).*

The role of primary care as one of the most effective and proven early interventions to major mental illness and suicide should not be underestimated. Government reforms towards a more multidisciplinary approach to the diagnosis and treatment of mental illness suggest that greater value is being invested in the primacy of primary care. However, SPA believes this recognition requires increased support of primary care physicians and general practitioners in the form of additional education, training and resourcing to assist in the development of improved risk assessment and diagnosis times (which, at present, can be anywhere up to 10 years for bipolar disorder, for example).

Reports such as *Tracking Tragedy: A systemic look at homicide by mental health patients and suicide death of patients in community mental health settings* have previously shown that constraints on the availability and capacity of Australia's (mental) health care services may contribute to deaths by suicide (NSW Mental Health Sentinel Events Review Committee, 2007). In fact, systemic reviews of suicide estimate that "around a third of suicides may realistically have been preventable with more optimal care" (NSW Mental Health Sentinel Events Review Committee, 2007, p. vi).

Specific concerns raised by the *Tracking Tragedy* report highlighted gaps in assessment documentation, deficient duration and continuity of care, and poor ongoing risk monitoring (NSW Mental Health Sentinel Events Review Committee, 2007; see also Burgess et al., 2000). This is despite the fact that NSW Health staff guidelines on suicide risk assessment and management dictate that "clear concise documentation of observations, results of examination and clinical decisions are the most helpful process to assist management of an individual by a team" (NSW Health, 2004, p. 3). These guidelines also acknowledge, as does research in this area, that the first 28 days following discharge from a psychiatric inpatient facility is a period of increased risk for suicide (NSW Health, 2004; see also Meehan et al., 2006; Goldacre et al., 1993; Geddes & Juszczak, 1995; Appleby et al., 2001; Yim et al., 2004).

[This point is elaborated on in SPA's response to the role of targeted programs and services that address the particular circumstances of high risk groups in TOR f)].

The implication arising from such findings is that improved integration at critical transitions of inpatient and community-based care may well reduce the risk of suicide among at-risk individuals. However, Australia's public health services require long-term remedies, not just band-aid solutions, and the building of capacity for the effective treatment of mental illness and suicidality. One way of ensuring greater continuity of care for at-risk individuals leaving emergency departments may be to develop working partnerships between emergency mental health services and crisis hotlines. Such care extends beyond the boundaries of the traditional health and mental health care systems. Crisis hotlines also provide relatively low-cost, effective services to individuals seriously contemplating suicide and are available to all regardless of geographical barriers, appointment availability, or ability to pay.

SPA believes the predicament of discontinuity is exacerbated for those experiencing comorbidity, in that the separation of (or barriers between) alcohol and other drug services and mental health services negates the prospect of holistic health treatment. Subsequently, people with dual diagnosis are often "shuffled between services [that are] unable and

sometimes unwilling to treat both conditions" (Senate Select Committee on Mental Health, 2006, p. 18). To this end, SPA argues that greater attention should also be provided to the treatment of comorbid conditions and the development of suicide prevention strategies that target mental illness as a whole. One way to address these issues might be to place less emphasis on at-risk populations and more emphasis on why certain populations are at risk. Likewise, it may be beneficial to question, evaluate and more prominently promote those treatment options known to be effective in addressing mental illness and suicidal ideation.

[This point is elaborated on in SPA's response to the role of targeted programs and services that address the particular circumstances of high risk groups in TOR f)].

iv. Interactions between at-risk individuals and the criminal justice system

Suicide attempts in prison are significantly higher than the general population, although the rates of suicide and the characteristics of inmates who are suicidal vary, depending on the type of correctional facility. Limited information is available for prison suicide attempt survivors. What is known, however, is that those who die through suicide within the first 24 hours of confinement tend to be charged with minor, non-violent alcohol and/or drug-related charges, with many of these individuals being acutely intoxicated at the time (Nock & Marzuk, 2000, Konrad et al., 2007).

Conversely, for prison suicides, those charged with manslaughter appear to be at much higher risk. Most prison programs focus on the increased recognition of mental illness as well as (often) end-stage strategies to avoid attempts (for example, isolation and housing of inmates in solitary cells, close observation, and removal or control of hanging and jumping points) rather than aiming for holistic prevention and treatment strategies (Nock and Marzuk, 2000).

Although there is currently very limited empirical literature on the impact of involuntary and solitary confinement of prisoners who attempt suicide (Konrad et al., 2007), programs aimed at increasing social support in and outside of prison may help reduce suicidal behaviours (Konrad et al., 2007). Schemes such as the peer-to-peer support Listener Scheme from the Samaritans have been shown to be useful to prisoners who are feeling despair or distress as a result of being incarcerated (Samaritans, online).

RECOMMENDATIONS – TOR c)

1. Develop and implement strategies aimed at de-stigmatising those affected by suicide and suicidal behaviours, including the promotion of improved understanding among first responders and health care professionals of the suicidal state and suicide bereavement.

2. Ensure culturally sensitive grief and coronial support services to meet the specific needs of individuals and communities, including those of highly vulnerable population groups; most notably, Australia's Indigenous populations, but also those bereaved by suicide (particularly children and youth), men, people with mental illness and their families and friends, and gay, lesbian, bisexual and transgender (GLBT), immigrant, CALD, and rural and remote communities.

3. Encourage proactive and standardised follow-up support and compassionate response during police investigations and coronial processes across all Australian jurisdictions. This should include the provision of information about support services available to families and friends bereaved by suicide, and a single point of contact for assistance during the coronial process.

4. In consultation, create and trial improved support mechanisms for first responders, coronial staff, therapists, clinicians, (mental) health services staff and general practitioners following the suicide of a client or patient, to assist with their own grief and emotional responses and to prevent personal and professional burnout.

5. Improve support mechanisms for witnesses of suicide and suicide attempt.

6. Increased support of primary care physicians and general practitioners in the form of additional education, training and resourcing to assist in the development of improved suicide risk assessment and diagnosis times for early interventions to suicidal crisis.

7. Support training of all emergency department staff in current suicide risk assessment protocols.

8. Increased funding, research and support to develop appropriate strategies and treatments to support suicide attempt survivors in emergency department settings.

9. Improved completion of assessment documentation, duration and continuity of care (including integration at critical transitions of inpatient and community-based care) and ongoing risk monitoring, particularly of high risk individuals such as recently discharged psychiatric inpatients.

10. Commission research to examine the work of individuals and teams who first respond to suicide and suicidal crisis, and their impact on future help-seeking by suicide attempt survivors and those bereaved by suicide. Especially investigate the role of peer support survivors.

11. Commission research on developing working partnerships between emergency mental health services and crisis hotlines.

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

13. Develop prison programs that focus on holistic suicide prevention and treatment strategies rather than solely end-stage strategies to avoid suicide attempts.

14. Commission research on the impact of involuntary and solitary confinement of prisoners who attempt suicide.

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

Although anti-stigma campaigns flourish in mental health, de-stigmatising self-harm and suicide remains both controversial and challenging. Suicide is undeniably a confronting issue in which complex social, cultural, economic, psychological and familial circumstances are often intricately woven in ways not well researched or understood, and into sensitive areas where vulnerabilities are pronounced. For some, these vulnerabilities may be difficult to acknowledge, accept and seek assistance for (Wensley, 2008). However, overarching concerns about inappropriate media reportage increasing suicide rates, and public discussion normalising suicide, must be balanced against the costs of silence about a major social problem (De Leo et al., National Committee for Standardised Reporting on Suicide, 2009).

> *"I was not aware and had no idea of what to do if I suspected someone had suicidal thoughts. I still do not know how I would help someone; what exactly I need to do or say. My suggestion is that ways of helping should be explicit, spelt out".*
>
> ***-- Personal story submitted to SPA, Submission 043***

Although individual and social attitudes to suicide are slowly changing, they remain deleterious enough to limit the support that is available to at-risk individuals and the suicide bereaved. As previously outlined elsewhere in this submission, the legacy of shame and social ostracism often associated with suicide can have a significantly detrimental impact on help-seeking behaviours among at-risk and bereaved individuals; resulting in a disinclination to consider professional support as warranted or to subsequently accept care and assistance when it is offered. The shame and humiliation resulting from the stigmatisation of suicide can often silence individuals altogether – hence, why SPA remains committed to facilitating opportunities for the diversity of voices and personal stories of those with lived experience to be heard in a safe and conducive environment.

> *"On reflection, I kept returning to one word: silence – in three different contexts. (i) The voice that represented mateship, compassion, care, truth, honesty, equity, loyalty and life itself was now silent. (ii) The precursors to his [friend] suicide were to me silent. I knew not of his troubles, medication or attempts to seek help. (iii) In a strange paradox, I find myself reflecting on my mate's life in silence. I don't know what to say to his parents and find discussions about him difficult".*
>
> ***-- Personal story submitted to SPA, Submission 067***

> *"We [the bereaved] are forgotten and we are here alive and need help to adjust to our new life with stigma and tags on our backs".*
>
> ***-- Personal story submitted to SPA, Submission 049***

> *"The stigma attached to suicide prevents bereaved people from being able to share their feelings with the general community. Yet, bereaved people want to alleviate the feelings of loneliness…On the whole, I felt alone and devastated. There didn't seem to be anyone on earth who had been through my experience, because nobody talks about it".*
>
> ***-- Personal story submitted to SPA, Submission 029***

Many damaging misconceptions remain about suicide. Both the literature and SPA's own stakeholder and member consultations endorse this indicating, in particular, an ongoing tendency for many individuals (health professionals included) to assume suicide to be (only) a medical problem; more often than not, a response to mental illness. This association obviously and detrimentally ignores the social determinants of suicide and self-harm in Australia.

Of greater concern, however, is the suggestion made by a number of individuals who submitted their personal stories and experiences to SPA that antiquated myths continue to flourish; influencing both public and professional attitudes towards suicidal ideation and suicidal behaviours more generally, but also cases of self-harm. Examples include: "if they talk about it, they won't do it"; "talking about it gives people ideas"; "not much can be done to prevent it, as people who are serious about it will do it no matter what anyone tries to do".

> *"I have spoken to heaps of people and they say they would not talk to their kids [about suicide] as they will put the idea in their heads. It is so important to get rid of the myths. One lady…who contacted me (whose daughter had just taken her life) was told by doctors and counsellors that her daughter would be okay because she was saying she wanted to die, so she didn't mean it. She was just after attention".*
>
> ***-- Personal story submitted to SPA, Submission 078***

> *"I think people are prepared to help, but the big problem is that most people don't recognise when someone is suicidal. I later found out that my husband had told many of his male friends…but no-one believed him and thought he was being dramatic. I also found out that he was told about someone who took his own life the same way just days before he took his own life".*
>
> ***-- Personal story submitted to SPA, Submission 044***

The prevalence of such attitudes in Australia is unknown. SPA is aware that Lifeline Australia is conducting a survey to shed light on such attitudes, which by implication affect people's willingness to seek help for themselves and/or for others experiencing suicidal thinking or ideas.

> *"I don't think most of the public know that many people who did not die as a result of their attempt at suicide actually want to live after that experience. Some say as they were falling from a bridge they changed their mind. Ones that fell into a river and surfaced then swam to the shore. None of us would want to die if the pain could be removed by a different method".*
>
> ***-- Personal story submitted by SPA, Submission 048***

i. A new approach to raising awareness about suicide and suicide prevention

With at least a decade of significant amounts of time, money and energy dedicated to raising the public profile and awareness of issues related to suicide, the question remains why such obvious examples of misunderstanding prevail. There is a need to ask what it is, in particular, about public awareness campaigns to date that has not sufficiently encouraged the anticipated and widespread reform of social and clinical attitudes towards suicide and self-harm in the community.

Such an approach obviously demands absolute critical reflection on the part of the suicide prevention sector in Australia, and its many stakeholders (including government). It is not to normalise or accept suicide, but rather to acknowledge its presence, its tragic avoidability, and the devastating secondary impacts suicide has on so many people, including its capacity to isolate, to exclude, to silence, and to alienate.

This therefore highlights the need for a revision, and possibly a reinvention, of the current approach to public awareness and suicide prevention initiatives. SPA proposes that these might be better positioned under the banner of a coordinated and well-funded (and resourced) national community awareness campaign that considers seriously the benefits of broad media engagement in its endeavors to achieve widespread systemic reform, and the government's broader adoption of the emphasis on preventative care.

SPA's vision for this coordinated approach anticipates a national suicide awareness campaign that takes its lead from previously successful community health campaigns, such as tobacco, HIV/AIDs and road trauma, to strongly promote messages of hope, help-seeking, resilience, social inclusiveness and wellbeing among individuals and communities, while at the same time tackling the stigma associated with suicide and self-harm. The need for a campaign of this type was supported and reiterated by a number of individuals who submitted their personal stories of experiences with suicide and self-harm to SPA.

"What we need as a community is some help knowing how to build healthy relationships, and knowing what isn't. We teach kids at school about drugs, why not teach them about good behavior in our personal relationships…?"

-- Personal story submitted to SPA, Submission 007

"Extensive public advertising campaigns educating people about suicide and how to react appropriately if they are faced with it (like the drink drive campaign). Extensive education for teachers in schools so that they may deal appropriately with students, but also education at school level so that students learn at an early age how to cope so that they may support friends or family members. Training in workplaces would also be useful…I see changing our culture so that we are able to communicate openly about suicide as crucial in preventing suicides. It would enable friends, family, co-workers, employers, teachers etc to better support people who are suicidal".

-- Personal story submitted to SPA, Submission 005

"When people do talk they reveal how they have found it difficult to know how to approach someone at risk. The main concern is if they say the 'wrong' thing and this is often what stops them from attempting to talk at all…I think having a permanent article in the newspaper placed prominently, offering information about help would be a good start. Also placing notices in as many public buildings as possible, on train stations, doctors surgeries, on buses and trains. We need a saturation of information".

-- Personal story submitted to SPA, Submission 048

Such a campaign will need to engage with and form connections to other relevant social agenda issues, including homelessness, bullying, and substance abuse (drugs and alcohol), and the impacts of ongoing challenges such as the global financial crisis and climate change. It will require strong leadership and a clear understanding of the need to capitalise on current understandings of suicide epidemiology and risk and protective factors, with continued rigorous research and scholarship into knowledge areas requiring greater awareness.

SPA holds no illusions: the challenge of developing such a national community awareness campaign is nothing short of substantial, albeit necessary.

"There is only one way to perform CPR for someone without a heartbeat who is not breathing. However, there are numerous ways to assist someone who is having thoughts of suicide. We need one major approach. We need to be united and focus on providing a community-wide program where we speak the same language".

-- Personal story submitted to SPA, Submission 070

ii. Developments in suicide awareness campaigns to date

SPA's advocacy for a renewed national community awareness campaign in no way overshadows the significant achievements and effectiveness of many suicide prevention initiatives and awareness-raising projects to date – a number of which have provided a solid foundation from which to develop greater consensus in the sector (and beyond) about communicating on the issues of suicide and suicide prevention via a newly-developed national awareness campaign that reaches the *whole of the community*.

SPA has established a Suicide Prevention Communications Think Tank with partners, such as Lifeline Australia, to advance the agenda of developing mutually agreed ways in which to communicate, advocate and educate on the issues of suicide and self-harm in Australia.

Examples of initiatives that have provided sound evidence for the broad social impact that effective community awareness campaigns can derive with regards to providing information, encouraging help-seeking and enhancing public awareness of suicide-related issues have elsewhere been referred to throughout this submission.

[Please note, in particular, reference to examples of successful and aspirational evidence-based suicide prevention initiatives in the introductory section of this submission and in SPA's response to TOR f)].

Two significant highlights include, to reiterate, the advancement of major national education and awareness-raising campaigns in the area of mental health and wellbeing (e.g. *MindMatters* and *beyondblue: the national depression initiative*) and the development of voluntary guidelines for media coverage of suicide, self-harm and mental illness (advanced primarily through the *Mindframe National Media Initiative in Australia*). Another, more recent, example is the development of RUOK?Day, a new annual national day of action that aims to get Australians from across the entire spectrum of society connecting with friends and loved ones on the early intervention and prevention of suicide.

SPA's annual *LIFE Awards*, held in conjunction with World Suicide Prevention Day (WSPD), aims to raise awareness of much of the work being done in these areas, while celebrating the achievements and contributions of Australians to suicide and self-harm prevention, intervention and postvention in Australia.

[Further examples of successful suicide prevention initiatives can be found among the lists of previous SPA LIFE Awards winners and honourable mentions, which are available for download from the SPA website].

Events such as community forums, national conferences, and broad stakeholder consultations and engagement in the development of research and policy frameworks and priorities continue to underpin the efficacy and reach of community awareness campaigns related to suicide and suicide prevention in Australia. Feedback from previous SPA member consultations would suggest that these opportunities for on-the-ground engagement significantly contribute to the promotion of help-seeking among vulnerable population groups while opening up a dialogue between the community and other key stakeholders in the suicide prevention sector.

Evaluation responses received from participants at the WSPD 2009 SPA Community Forum, *Isolation: A Western Australian Perspective and Help-Seeking*, validate the opportunity such events offer for pathways to hope and the facilitation of open dialogue between members of the public and professionals involved in areas related to suicide (e.g. coroners and policy decision-makers). A number of WSPD 2009 SPA Community Forum participants expressed, in particular, an appreciation of being able to connect and network with and hear from others (a diversity of voices) with personal and lived experiences of suicide and self-harm.

The shortfall of SPA's WSPD activities, as with a number of other suicide prevention-based events more broadly, is that despite their professionalism and the tangible benefits they deliver to broader community engagement and awareness-raising, resources for regular events of this nature remain limited. SPA, for example, has the capacity to fund and resource WSPD activities in only one capital city each year. We suspect many other organisations experience similar resourcing constraints. There is reason to suggest therefore that, in addition to increased funding of suicide prevention activities under the auspices of WSPD, there is a need for a national WSPD steering committee to ensure that Australian WSPD events and activities are integrated and coordinated under the banner of a national community awareness campaign, and are able to deliver a consensus of message to all parts of the community, including regional and remote areas of Australia.

RECOMMENDATIONS – TOR d)

1. 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.

2. 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.

3. There is a need for informed debate and decision-making within the suicide prevention sector (and beyond) on ways in which to communicate, advocate and educate on the issues of suicide and self-harm in Australia. The outcomes require properly resourced evaluation.

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. Develop a national World Suicide Prevention Day (WSPD) Steering Committee to ensure that WSPD events and activities are integrated and coordinated under the banner of a national suicide awareness campaign, and engage all parts of the community, including regional and remote areas of Australia.

6. Greater engagement of the suicide prevention sector with mainstream, community and multilingual media to raise awareness of suicide and how to responsibly report on suicide-related issues.

7. Ensure programs related to the issue of suicide connect to other relevant social agenda issues, including homelessness, bullying, and substance abuse (drugs and alcohol), and the impacts of ongoing challenges such as the global financial crisis and climate change.

e) The efficacy of suicide prevention training and support for frontline health and community workers providing services to people at risk

While there is no universal principle or model for responding to a suicide death, a number of guidelines have been published in the Australian context to assist specific population groups (e.g. school students) and communities, more broadly, in the development and delivery of suicide postvention strategies and support (see, for example, Department of Communities, 2008; Department of Education and Children's Services et al., n.d; SANE Australia, 2009). SPA commends these efforts while recognising that, unfortunately, the development (and review and update) of such guidelines tends to be an exception rather than the norm.

In many cases, the information distributed on 'best practice' suicide prevention, intervention and postvention strategies is outdated. This is not intended to undermine the efforts of those organisations admirably attempting to support frontline health and community workers through the widespread dissemination of such guidance and information resources, but rather to highlight the urgent need for rigorous review (and revision where necessary) of the messages being distributed, with a strong emphasis on the development of updated 'best practice' guidelines and competencies related to supporting individuals bereaved by suicide. In short, there is a growing need to investigate the evidence contributing to the effectiveness of frontline service provision and responses to at-risk individuals and those in crisis.

Development of 'best practice' standards and accreditation for all service delivery and training is therefore essential. SPA commends programs such as Lifeline Australia's workforce development project, *Suicide Bereavement Support Group Standards & Practice Project*, which has commenced the development of nationally accredited competency-based training materials and training, implemented to prepare suicide bereavement support group facilitators. SPA more broadly supports the continued provision and refinement of similar training programs adapted to the context of different support and service delivery settings.

We also strongly advocate for the establishment of an independent body to oversee and contribute to the process of national accreditation and standards for all service delivery and training, drawing on international examples, such as the Suicide Prevention Resource Center in the United States (see http://www.sprc.org), which has been been cited as a 'best practice' model of a technical assistance and resource centre, aimed at building capacity for states and communities to implement and evaluate suicide prevention programs.

i. The evidence for improved suicide prevention training and support

The evidence for effectiveness of increased and improved training and support for communities and for frontline health and community workers is overwhelming. For example, specialised training of professionals who have contact with people bereaved by suicide has previously been shown to reduce the stresses for these individuals (Hawton & Simkin, 2003). Likewise, increased support of primary care physicians and general practitioners, in the form of additional education, training and resourcing, has been shown to assist in the development of early interventions for at-risk individuals through improved risk assessment and diagnosis times (Mann et al., 2005, p. 2067; Pfaff, Acres, & McKelvey, 2001).

Internationally, up to 83 per cent of individuals who suicide have had contact with a primary care physician within a year of their death and up to 66 per cent within a month (Mann et al., 2005; Luoma, Martin, & Pearson, 2002; Andersen, Andersen, Rosholm, & Gram, 2000). Yet, depression and other mental illnesses are often under-recognised and under-treated in primary care settings (Mann et al., 2005).

As Goldney (2008) points out, by way of example, a common theme among a number of studies maintains that mood disorders have often not been diagnosed in many of the individuals who have died by suicide. In instances where they had been, those people had often not received "adequate treatment for their depressive conditions" (Goldney, 2008, p. 28). Thus, writes Mann and colleagues (2005, p. 2065), a key prevention strategy could well be the "improved screening of depressed patients by primary care physicians and better treatment of major depression".

An example of this includes a previous Australian program that provided training to primary care physicians to assist in the recognition and response to psychological distress and suicidal ideation in youth. The training increased identification of suicidal patients by 130 per cent, though unfortunately this was "without changes in treatment or management strategies" (Mann et al., 2005, p. 2067; Pfaff, Acres, & McKelvey, 2001).

> *"Doctors, as they are often the frontline, should have more training as to the best way to help those bereaved – that is, seek help rather than medicate".*
>
> ***-- Personal story submitted to SPA, Submission 032***

SPA has also previously argued that suicide attempt survivors require better support in the time leading up to a suicide attempt, during the suicidal crisis, and after the event. To help facilitate this, increased funding, research and support is required to develop appropriate strategies and treatments to support suicide attempt survivors in emergency department settings. Strategies may include education and training of hospital staff with peer survivor training of

health professionals more generally. At a minimum, more adequate support for psychiatric patients in public hospital emergency services is required by way of additional staff support and training in mental health and suicide prevention awareness. It is anticipated that the more harmful implications of stigmatising attitudes and punitive responses expressed by some health professionals towards suicide attempt survivors may diminish with greater understanding through improved training and support.

> *"During the course of my adult life, I have attempted suicide three times. On each of these occasions, I was admitted into Mental Health Units through short stays in Accident and Emergency Departments... On each of these occasions, I believe I was engaged in a disrespectful manner. Staff were prone to offer accusatory suggestions, extremely harsh criticism and, on one occasion, after being temporarily transferred to a medical ward, when staff were informed I experienced schizophrenia, expected me to be violent or aggressive in behaviour. When escorted to the Mental Health Unit, I was told I had been a good patient. This response to individuals experiencing trauma and extreme distress is unacceptable".*
>
> ***-- Personal story submitted to SPA, Submission 019***

With regards to individuals bereaved by suicide, SPA has previously advocated for the promotion of quality assurance and training of bereavement support groups, and the promotion of evidence-based 'best practice' principles as the foundations for all suicide bereavement outreach services and postvention initiatives *[see SPA Position Statement, Suicide Bereavement and Postvention, for more information].* There is likely also a role here for SPA to play in facilitating face-to-face briefing opportunities with frontline health and community workers, and service providers more broadly, on the findings that emerge from the community consultation and development of its relevant SPA Position Statements.

ii. Building the capacity for culturally sensitive and specific crisis care

In Australia's rural and remote areas, cluster randomised controlled trials and evaluation of mental health first aid (read: mental health response training) has demonstrated that such training has the potential to raise the mental health literacy of a community to bring about positive changes in knowledge, attitudes and behaviour towards mental health problems and people with mental disorders (Jorm, Kitchener, MacTaggart Lamb, & Brand, 2007). SPA believes it is important that mental health first aid, complemented by suicide prevention training, reach as many members of the community as possible, with particular priority given to remote, rural and regional Australia; bearing in mind that it is, quite often, family members, work colleagues, teachers, and/or sports coaches who are the first responders to an individual at-risk or in crisis in these areas.

> *"Think about the people in regional and rural Australia who are so much more isolated than those in the city – extend services there as a matter of priority. In our small town, there have been three suicides in as many years".*
>
> ***-- Personal story submitted to SPA, Submission 038***

> *"Most people who are suicidal come to the attention of friends, neighbours, GPs or the emergency departments of the local hospitals. Only 20% come to the attention of mental health, and this is true of my district…I would suggest further that all clinical staff working within any health system become proficient in identifying and managing suicidal behaviour or risk".*
>
> ***-- Personal story submitted to SPA, Submission 025***

> *"It is the role of the community to know suicide first aid, just as it is for them to know physical first aid. We need to have openness about suicide… People need to know that others, their neighbour, teacher, passer-by can help them if they have a need. We require a community response".*
>
> ***-- Personal story submitted to SPA, Submission 070***

As previously reiterated in TOR c), the vicarious trauma and impact of suicide (particularly where the deceased was a patient or client) on first responders and frontline health and community workers, and whole communities more broadly, should not be underestimated and should, in fact, receive greater attention than what it traditionally has in discussions of suicide prevention and policy and strategy development. Support mechanisms for these individuals following the suicide of a client or patient should be made mandatory to help both professionals and service providers with their own grief and emotional responses and to prevent personal and professional burnout.

Similarly, SPA argues that individuals, such as Rural Financial Counsellors, support workers, teachers, sports coaches, and small businesspeople in Australia's remote, rural and regional areas, should be provided with the requisite training to independently refer clients in crisis to the most appropriate and available mental health and health care services and resources (while also acknowledging their own stresses and emotive responses to such crises). We are aware that such training is currently being rolled out in New South Wales (NSW) under the auspices of the *NSW Farmers Blueprint for Mental Health and Wellbeing* and NSW Farmers Mental Health Network (see http://www.aghealth.org.au/blueprint/link12.html), and are encouraged by this initiative and its focus on building resilience among farming communities.

These examples highlight the need not only for improved suicide prevention training, support and awareness, but more especially, the need for this training to build capacity for *culturally sensitive* and *culturally specific* responses to individuals and communities at high risk of suicide and self-harm. Gay, lesbian, bisexual and transgender (GLBT) health and community service providers, for example, acknowledge that many currently lack the capacity to effectively undertake mental health promotion and suicide prevention work; citing an absence of knowledge, skills, and resources as the key barriers. Conversely, mainstream mental health and suicide prevention organisations highlight gaps in current understanding and awareness of GLBT needs, resulting in inadequate service delivery.

> *"Obviously, for me, the counsellor or service I am dealing with needs to be open to my sexuality…My sexuality is not something I am prepared to hide in order to access help. This needs to be taken into account across all services. They need to be open to a variety of backgrounds and the staff need to leave their prejudices at the door".*
>
> ***-- Personal story submitted to SPA, Submission 004***

This raises the question of whether frontline health and community workers more generally consider themselves adequately resourced, trained and supported in the delivery of suicide prevention services and assistance to individuals in suicidal crisis. SPA anticipates that the Committee will receive submissions from other organisations more qualified (being at the coalface of service provision) to respond on this point, and urges the Committee to consider this line of questioning in order to ascertain first-person responses.

Clearly, however, many service providers, but particularly those in culturally specific communities, require increased resources to build their capacity to deliver adequate and accessible services and undertake targeted suicide prevention and mental health promotion activities and training; supporting mainstream suicide prevention initiatives. Additionally, further 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) is also vital to building community strength and the prevention of suicide and self-harm.

> *"The after affects of the suicide were horrendous. There was no support for me and my family. We did not know where to go for support as we did not really know how to deal with this at the time. I find that very little help is available to families during the time of the suicide and whilst you are grieving, making arrangements for funerals etc".*
>
> ***-- Personal story submitted to SPA, Submission 077***

RECOMMENDATIONS – TOR e)

1. Implement improved mental health and suicide prevention training, education and supports for frontline (mental) health and community workers to recognise and assist people who are experiencing a suicidal crisis, and reduce stigmatising attitudes and behaviours towards suicide attempt survivors and the bereaved.

2. Develop national accreditation and 'best practice' standards for all service delivery and training.

3. Establish an independent national suicide prevention accreditation and standards agency, drawing on international 'best practice' standards, to manage the accreditation and evaluation of suicide prevention service delivery, training and programs.

4. There is a need to examine the current evidence contributing to the effectiveness of suicide prevention service provision and interventions for at-risk individuals and those in crisis, with a view to revising (where necessary) current 'best practice' guidelines for frontline health and community workers.

5. Develop timely, robust and transparent reporting systems to ensure information on suicide prevention programs is readily available and updated.

6. Support quality assurance and training of bereavement support groups, and the promotion of evidence-based 'best practice' principles as the foundations for all suicide bereavement outreach services and postvention initiatives.

7. Support accessible mental health first aid and suicide awareness training for the general community, but particularly 'first responders' in remote, rural and regional areas (e.g. small businesspeople, teachers, Rural Financial Counsellors, sports coaches) to allow independent referral of clients in crisis to the most appropriate and available mental health and health care services and resources. This should also involve acknowledging these individuals' own stresses and emotive responses to such crises, and reviewing means of obtaining personal support.

8. Develop formal policies and strategies for institutions, such as schools, universities, workplaces and other community settings, to assist with the re-integration of suicide attempt survivors.

9. 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.

10. 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.

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

As reiterated in the introductory section of this submission, SPA has previously identified and examined the challenges inherent to a number of higher risk groups for suicide through its ongoing series of SPA Position Statements: http://suicidepreventionaust.org/PositionStatements.aspx

What follows by way of SPA's response to the above TOR therefore draws heavily on the research and community consultation previously conducted in the process of developing these documents. Rather than simply comment on the role of targeted programs and services for individuals at high risk of suicide and suicidal behaviours, however, we have opted to also focus our response around the circumstances particular to each of these population groups, with a view to determining why some programs and services are better targeted towards high risk individuals over others.

Given the constraints of this submission, the Committee should note that what follows is a series of abbreviated responses, distinguished by high risk population group, and should not be misinterpreted as a comprehensive overview of the complexities of suicide risk and crisis response for each of the nominated population groups. For a more complete examination of these priority areas of suicide prevention, intervention and postvention, the Committee is referred to further reading of each SPA Position Statement in its entirety.

i. Men and Suicide

Suicide among men of all diversities remains one of the more complex and challenging, yet preventable, health issues facing Australian communities today. Five men die each day by suicide in Australia. SPA acknowledges that men become suicidal in response to complex social issues, illness and other individual processes that often isolate them and erode their hope. This risk is something to which *every man* is potentially vulnerable.

SPA believes initiatives that encourage help-seeking among men, remove the barriers to continuity of care and replace the negative aspects of gender stereotyping (with empowering and positive ways in which men can see themselves as contributors to society), have the potential to greatly reduce the rates of male suicide and self-harm in Australia. We are therefore heartened by the Australian Government's undertaking to develop a National Men's Health Policy as the culmination to its Men's Health Policy forums and consultations, which have been ongoing around Australia. An approach that builds the community capacity of men by men and in support of men is essential.

Given that one of the most significant risk factors associated with male suicide is a lack of support and the reluctance and/or inability of men to recognise and identify their own risks (for example, those traumatised earlier in their lives can exhibit a detachment from their risk-taking behaviours), it is essential that the concept of 'help-seeking' is normalised among Australian men – starting at school age and continuing across the lifespan. As a result, we support the advocacy of stronger strategies addressing bullying, particularly of gay youth and among youth in rural areas, and 'proactive' programs that that seek to identify those men who may be at risk, but who do not necessarily self-identify as such.

Currently, many health and primary care services do not have the capacity to deal with complex presentations of male problems, such as co-morbidity of substance misuse and mental health problems, the effects of social isolation, sexuality, or separation of fathers from families and children. There is, therefore, an urgent need to address the program, structural and policy barriers that inhibit continuity of care, help-seeking and the quality of support for all Australian men with a focus on the delivery of appropriate promotion and prevention efforts within the settings where men live, work and recreate (*A Blue Print for the Future*, 2006).

Strategies such as FamilyCare's *Coach the Coach* program (see http://www.coachthecoach.net.au) – an initiative that trains sporting coaches in mental health first aid – is a good example of these principles in practice. Reaching out to young men in rural towns through their football teams and sporting networks, the program aims to increase recognition of mental health and wellbeing, encourage help-seeking behaviours, and decrease male suicide rates.

Programs such as these exemplify the potential of sporting clubs, recreational clubs, workplaces and other organisations more generally to construct supportive social networks in places where men frequent in an attempt to lessen harmful behaviours and practices, such as the excessive consumption of alcohol. This is in keeping with the recommendations from both the Primary Health Care Strategy and the National Health and Hospitals Reform Commission reports, and the renewed focus on community-based services closer to where (at-risk) people live and work.

ii. Suicide Prevention and Capacity Building in Australian Indigenous Communities

While the prevalence of suicide in Indigenous communities has been shown to be significantly higher than that of non-Indigenous populations, Indigenous understandings and definitions of suicide and self-harming behaviours remain under-researched, undervalued and under-utilised. What is known is that the risk of suicide and self-harm among Indigenous communities is complicated and compounded by complex intergenerational transmissions of violence, trauma, grief, (de)colonisation, racism and loss. The effects of these are known to greatly contribute to sociocultural and economic problems and conditions, which in turn place Indigenous individuals at greater risk of suicide and self-harm.

Also, as noted above, Indigenous suicides (and other deaths) are frequently not effectively identified as Indigenous, and action is required to remedy this. The Australian Bureau of Statistics (ABS) does not currently report suicides by children under 14 years, which are extremely rare in the general community, but certainly have been reported increasingly in some Indigenous communities in recent decades.

SPA recognises that strategies aimed at reducing the rate of suicide among Indigenous communities must be culturally based to recognise and support the differences between Indigenous groups. They must also embrace genuine consultation with existing providers of Social and Emotional Well Being (SEWB) services, Indigenous organisations providing grief and loss support, Indigenous researchers and policy-makers and particularly the groups for which they are intended, rather than indiscriminately adapting non-Indigenous models of suicide prevention and assumptions of suicide risk. Central to this is the misconception that Indigenous suicides are typically a response to clinical depression. The role and potential of community-based, family-centred care giving and 'self-determination' as a protective factor must not be underestimated in this.

In this context, SPA thoroughly supports research and/or resourcing for Indigenous drug and alcohol and tobacco programs, and for maternal and child health, as key components to effective suicide prevention. Most importantly, the focus must now shift from talk to tangible outcomes for Indigenous communities.

In particular, postvention and responses to the enduring grief experienced within Indigenous communities as a result of suicide and self-harm must be addressed as a matter of priority, and should particularly consider the needs of children and young people who are impacted by suicide. They should also consider the development of more counselling services and training for mental health workers responsible for the service and care of Indigenous peoples.

In developing and implementing Indigenous suicide prevention strategies, it is important to recognise that no 'quick fix' solution exists to the complex web of underlying sociocultural and economic problems and conditions found to greatly contribute to increased occurrences of at-risk individuals and endemic rates of suicide and self-harm among Indigenous peoples. In recognising this, however, SPA is concerned not to perpetuate the perception that Indigenous health remains an insoluble problem. Indeed, many reports exist regarding Indigenous health, wellbeing and safety[1], whose recommendations could be reviewed, collated and effectively translated into tangible outcomes for Indigenous peoples by way of implementation and action. Moreover, there are presently a number of carefully evaluated best practice community intervention and capacity building programs and initiatives from different institutions and disciplines, which offer hope and important learnings about Indigenous suicide prevention (for examples, see the work of Tracy Westerman, Judy Atkinson and others referenced in a recent paper by Petchkovsky, Cord-Udy, & Grant, 2007; the Yarrabah Family Life Promotion Program; and work by the StandBy Response Service in this area). Such work should be properly resourced, supported, evaluated and expanded.

iii. Responding to suicide in rural Australia

While research reflects substantial differences between rates of suicide in rural and urban areas, a relative deficit of literature exists in relation to the underpinning social determinants that contribute to elevated suicide risk in rural Australia. One frequently cited contributor is depression. More recently, however, longstanding challenges faced by rural communities have been compounded by the effects of climate change (the full ramifications of which are yet to be determined). This has led to international trade pressures and socio-economic decline; typically resulting in significant social and human costs, such as depopulation, financial indebtedness, the guilt and shame often experienced as a consequence of financial vulnerability, and an increased reliance on alcohol and other substances as a method of escaping difficult life experiences. These factors have been shown to be major precipitators to increased suicide risk among both younger and older, as well as Indigenous and migrant rural Australians.

SPA recognises that strategies aimed at reducing the rate of suicide and self-harm in rural and remote areas must address these factors as well as others, such as the impact of social stigma as a significant inhibiting factor towards help-seeking in rural communities. Access to firearms remains an issue of considerable concern also, given that the high lethality of such methods may convert many attempts into completed suicides as a consequence of the presence of a firearm (Baume & Clinton, 1997; Cantor & Slater, 1995). The role of improved mental health literacy, accessibility of services and resources, and coordinated initiatives that encourage help-seeking therefore remain central to minimising the risk of suicide and self-harm in these areas.

Due to geographic constraints, rural areas often suffer from a shortage of health care facilities such as hospitals and clinics, and have difficulties in attracting and retaining new service providers and health care professionals (Hirsch, 2006). Where mental health and health care organisations do exist, these are usually under-funded, comparable to urban areas.

The communal nature of rural communities, and non-traditional health service delivery mechanisms, including farm visits from financial counsellors and organisations such as Aussie Helpers and Black Dog Institute, and online technologies such as telepsychiatry and electronic social networking, should therefore not be overlooked as protective factors to the risk of suicide and self-harm among rural individuals (Hirsch, 2006).

Research by Fragar and colleagues (2008) suggests that activities currently being implemented by the NSW Farmers Mental Health Network partners address a number of these issues, and represent a broader framework and set of

[1] The Royal Commission into Aboriginal Deaths in Custody, and more recently, the *Little Children are Sacred* report, produced by the Northern Territory Board of Inquiry into the Protection of Aboriginal Children from Sex Abuse; *Close the Gap: Solutions to the Indigenous Health Crisis facing Australia* policy briefing paper prepared by the National Aboriginal Community Controlled Health Organisation and Oxfam Australia; and the Blank Page Summit (Western Australia) are just four examples.

recommendations applicable to mental health promotion in other identified at-risk Australian populations. Programs conducted under the auspices of the *NSW Farmers Blueprint for Mental Health and Wellbeing* and NSW Farmers Mental Health Network include mental health first aid training among workers in the non-health sector who work closely with farmers (e.g. Rural Financial Counsellors), to improve their understanding of common mental health problems, reduce stigma and identify effective responses. This training is linked to a program aimed at developing local service networks that can more effectively collaborate between health services and non-health services, to promote mental health, ensure early intervention to appropriate levels of care through clearer referral networks, and promote better use of the counselling and health resources in rural communities (Fragar et al., 2008).

iv. Suicide bereavement and postvention

While a death in a close relationship can be one of life's greatest stresses, the grief following suicide has its own particular difficulties. Indeed, the bereavement specific to suicide can be said to be unique from other forms of bereavement following death; mostly as a consequence of the individual and social stigma frequently associated with suicide.

This can detrimentally impact a bereaved person's sense of self-worth and can result in a general reluctance towards help-seeking and any discussion of their clinical needs, concerns and emotional experiences, which can have a number of negative follow-on effects – not least of all, harmful impacts on the grief and recovery process and the potential for heightened risk of suicidal ideation and/or suicide attempts

Grieving is an intensely personal and individual process, and the bereavement journey following a suicide is typically prolonged. As borne out by the personal stories submitted to SPA, there is a need for continuity of care of the bereaved that extends beyond immediate follow-up after a suicide to longer-term care – even, in some cases, lifetime support. Many of these personal stories also draw attention to the fact that different people require different responses to their loss. For this reason, SPA believes it is vital that suicide postvention strategies, health care providers and other caregivers recognise the importance of no longer treating those bereaved through suicide as a homogeneous group (Clark, 2001).

For instance, studies show that, although helpful for many, for some individuals, bereavement programs and support may not always be a positive experience or indeed beneficial (McMenamy, Jordan, & Mitchell, 2008; Murphy et al., 1998; Lehman, Ellard, & Wortman, 1986). For others, the ideal time for professional support may not always be immediately following a suicide and many more may not feel ready to seek help at the time that it is offered (Provini et al., 2000). Individuals may also be impacted by the intergenerational post-traumatic effects of suicide a number of years after the death of a loved one or an associate. Greater flexibility in the delivery of existing services is therefore essential.

Effective postvention strategies and interventions can serve as a primary and secondary preventive to suicide among at-risk bereaved individuals. SPA believes that suicide postvention should therefore be considered as equally important as suicide prevention in bearing the very real potential to "avert future psychiatric and family dysfunction and even future suicides" (Jordan & McMenamy, 2004, p. 337). SPA maintains that suicide postvention should be reconfigured to more effectively promote the preservationist qualities and benefits of suicide bereavement strategies, support and intervention (as critical points of prevention) among first responders, clinicians and other health care professionals, services providers, researchers, bereaved individuals and the community more broadly.

Postvention responses should aim to avoid glorification (or indications of judgment or criticism) of the deceased person and the act of suicide and minimise sensationalism (particularly through media channels). Targeted programs and services should facilitate the early identification of other individuals who may be at-risk of harming themselves (including those experiencing anniversaries or dates of special significance).

The literature does suggest that individual, group or family counselling and psychotherapy may be of some benefit (Jaques, 2000). Hawton & Simkin (2003) and Clark (2001) also cite bereavement organisations and self-help groups as well as books written by bereaved individuals as other sources of information and practical support. Telephone counselling 'hotlines' may also be helpful for suicide bereaved individuals seeking emotional support.

An increased reliance on the internet and online networks for informational support and links to sources of practical and emotional support has also been cited in the literature. This may be particularly useful to bereaved individuals who are geographically isolated or are seeking anonymity and privacy or 24-hour availability, and a non-confrontational means of support (Clark, 2001; Hawton & Simkin, 2003). Web-based services such as *Reach Out* have also been noted for helping to improve the mental health and wellbeing of young Australians by providing online support information and referrals, including those related to loss and grief, in a format that appeals to young people. However, the risks and benefits inherent in the use of the internet and online social mediums as a means of support and practical information should be equally noted.

Recognising the additional difficulties experienced by children and adolescents bereaved by suicide, SPA has previously appealed for the introduction of mandatory suicide (and attempted suicide) postvention guidelines across all Australian educational institutions and schools, in addition to initiatives to improve the communication of grief, loss and suicide bereavement in age-appropriate ways among these vulnerable population groups.

In Australia, enhanced support and practical resources for suicide bereaved individuals have only recently started to gain greater prominence. Newly commencing work in this area includes, among others:

- The development of activities targeted towards suicide bereavement under the *National Suicide Prevention Strategy*;
- Circulation of bereavement support and resource kits;

- Lifeline Australia's *Suicide Bereavement Support Group Standards & Practice Project* (a workforce development project);

- SANE Australia's *Mental Illness and Bereavement Project*, including the *SANE Bereavement Guidelines* and DVD exploring real-life experiences of families bereaved by suicide;

- Outreach support and response services such as the community-based *StandBy Response Service*, Jesuit Social Services' *Support After Suicide*, the Salvation Army's *Living Hope* online bereavement support training program, Curtin University of Technology and the Telethon Institute for Child Research's 'Active Response Bereavement Outreach' Program (ARBOR) and Anglicare's *Living Beyond Suicide*;

- The Salvation Army's *National Hope Line* (1300 467 354) specifically for the bereaved by suicide, and the *Hope for Life National Lifekeeper Memory Quilt* (see http://salvos.org.au/suicideprevention), which provides a creative outlet for the grief of survivors as well as a touching, visual reminder of those lost to suicide, helping to reduce the stigma associated with mental illness and suicide; and

- Various other state-based suicide bereavement, grief and loss programs and postvention initiatives and guidelines.

However, SPA believes the need for improved and ongoing support of those bereaved by suicide in Australia is such that there remains a requisite need for the introduction of additional pragmatic evidence-based interventions and suicide postvention initiatives.

v. Suicide and self-harm among Gay, Lesbian, Bisexual and Transgender communities

SPA recognises that strategies aimed at reducing suicide and self-harm among Gay, Lesbian, Bisexual and Transgender (GLBT) communities must:

- Promote socially inclusive and supportive environments that affirm sexual and gender diversity. This, in itself, is a complex task that will require efforts to address the often hostile social environments in which many GLBT individuals live, work and study. Challenging homophobia and transphobia at the interpersonal, sociocultural, and institutional levels is critical.

- Be collaborative, multidisciplinary and incorporate both mental health promotion and crisis intervention strategies that are accessible and, where appropriate, are culturally specific to GLBT individuals.

It is important to acknowledge also the diversity within and between GLBT communities. Factors such as gender, age, cultural background, location and disability may significantly impact on life experience and the determination of appropriate responses to individual situations. Sexual orientation and gender identity should also be distinguished as independent from one another, while also recognising that individuals may or may not identify with the commonly used terms 'gay', 'lesbian', 'bisexual', and/or 'transgender'. It should also be recognised that conflicts between spiritual or religious beliefs and sexuality can result in significant psychological dissonance as well as division and exclusion from family, friends and community, and that there remains conflicting evidence regarding whether any association exists between HIV/AIDS and depression, suicide and/or self-harm.

Studies do support, however, the proposition that GLBT people utilise the internet as a primary means of learning more about sexuality and gender identity, as well as a way to connect with peers through participation in online communities and social networks (Hegland & Nelson, 2002; Hillier et al., 2001). Both Hillier et al (2001) and Hegland and Nelson (2002) report that the positive self-worth gained from online experiences further enables young people (in particular) to feel confident in coming out to their friends and families and seeking offline help to support them in coming to terms with gender identity and sexuality issues. More recently, research has also identified the significance of online communication to older people, indicating that older GLBT people could benefit from online intervention and support (Aguilar, Boerema, & Harrison, 2009).

vi. Supporting suicide attempt survivors

One of the main issues in providing help to suicide attempt survivors is that many do not seek help or come to the attention of health care professionals. In fact, less than half of those who attempt suicide receive medical attention (De Leo et al., 2005; Nock et al., 2009; Johnston et al., 2009).

> *"Too many precious, sensitive, irreplaceable human beings are dying from suicide. Why is it that we don't realise how low people are until it's too late? Why do we not take steps to tell each other the truth about the struggles we have with living life?"*
>
> ***-- Personal story submitted by SPA, Submission 039***

Moreover, when those who attempt suicide present to health services, mental health assessment is by no means assured, despite evidence that brief admissions improve assessment rates, and thereby greatly improve active follow-up (Kapur et al., 1999). Different models can provide appropriate settings for reflection, perspective and hope, where hospital wards may not – for example, pre-existing models such as 'crisis stabilisation units'. In the United States, these community-based programs allow people with a mental illness who require urgent/emergent need to receive crisis stabilisation services in a staff-secure, safe, structured setting that is an alternative to hospitalisation. Other models, such as Maytree in England and Parakaleo in Tasmania, provide one-off short-term accommodation in a supported non-medical environment.

These centres have unpaid, trained volunteers who are there to listen, talk and provide support to those staying at the centre (Maytree, online; Parakaleo, online). Similar to this model, peer-run respite programs or consumer-operated peer centres have been developed in the area of mental health (Mead & Macneil, 2004). These programs are based on the philosophy that crisis can be transforming and people who have similar experiences can better relate and offer authentic empathy and validation. Peer support can help people move through a difficult situation (Macneil & Mead, 2005). Such models may also be appropriate in the area of suicide prevention, although there is currently still limited information about for whom and under what circumstances such centres may be beneficial.

When a person who has attempted suicide comes to the attention of an emergency department, a prime opportunity opens up for intervention. However, the majority of those who do come to attention following a suicide attempt do not receive any subsequent help (De Leo et al., 2005). This is particularly the case among young people (especially young men) whose attendance at health services is low (Shaffer & Piacentini, 1993).

Non-attendance of suicide attempt survivors at follow-up interviews is also alarmingly high (Michel et al., 2009; Moller, 1990). Some researchers have estimated this non-compliance to be as high as 50 to 60 per cent (see, for example, Kurtz et al., 1998). This is of particular concern, given suggestions that the risk for further suicide attempts is the highest in the month after discharge (Immanuel & Wurr, 2001). Therefore, engagement, follow-up and maintaining contact with suicide attempters after emergency room contact is critical.

Recent studies have shown that maintaining contact with suicide attempt survivors or other high risk groups (e.g. psychiatric inpatients refusing follow-up) after discharge significantly reduces their risk of subsequent attempt and death. The interventions with young adults ranged from giving people postcards (Carter et al., 2005) to sending letters at least four or five times a year (Motto & Bostrom, 2001) to a dual intervention of a one-hour information session on suicidal behaviour as a sign of psychological and/or social distress, risk and protective factors, basic epidemiology, repetition, alternatives to suicidal behaviours, and referral options with nine follow-up contacts (phone or in person) over a period of 18 months (Fleischman et al., 2008). It was also suggested that when contact was reduced or ceased, the preventative effect also disappeared (Motto & Bostrom, 2001). These successes deserve widespread publicity and adaptation and/or adoption in local settings.

vii. Mental illness and suicide

Mental illness is one of the most common and significant contributing factors to suicide in Australia. The nexus between mental illness and suicide, however, is not necessarily defined by an uncomplicated one-to-one relationship. Many people who experience mental illness do not display suicidal thoughts or behaviour and not everyone who takes their own life can be said to be mentally ill – that is, a person does not need to have a mental illness for suicide risk to still be present (see Australian Government Department of Health and Ageing, 2007). High frequencies (up to 90%) of mental illness and substance misuse associated with suicide primarily reflect studies conducted in Western countries. Literature from non-Western countries is much scarcer and rates are apparently lower (Bertolote et al., 2003). Nonetheless, a suicide attempt can often be an early warning sign of a developing mental illness.

The strongest links between mental illness and suicide have been shown to include clinical depression, bipolar disorder, schizophrenia, alcohol and other substance use disorders, borderline personality disorder, and behavioural disorders in children and adolescents (Australian Government Department of Health and Ageing, 2007). It is important to note that mental illness affects each person differently. As such, appropriate and effective treatments will vary accordingly.

Notwithstanding, the contribution of pharmacological treatments (particularly lithium and clozapine) and the use of health services (often as one of the first points of clinical contact) are well regarded in the identification, assessment, and treatment of mental illness and suicide risk. Similarly, research shows that physician education in depression recognition and treatment; the restriction of access to means and lethal methods; and the promotion of more responsible reporting of suicide and mental illness can greatly contribute to reduced suicide rates (Mann et al., 2005). There has also been some authentication given to the effectiveness of self-management strategies, including use of the internet, telephone counselling, and self-help groups.

More formally, studies have shown that therapies such as cognitive behaviour therapy (CBT) and dialectical behaviour therapy (DBT) as well as family therapy and problem-solving therapy are often directly effective in reducing rates of suicidal ideation and suicidal behaviours; particularly through their management of depression and anxiety (see Burns et al., 2005).

Additional treatment options and crises services such as outreach interventions, which typically include regular telephone contact (e.g. Tele-Help/Tele-Check – see Fleischmann et al., 2008; De Leo et al., 1995; Termansen & Bywater, 1975) and home visiting, have also been highlighted as effective strategies for reducing social isolation and preventing suicide. Telephone contact, in particular, enables the detection of people at high risk of further suicide attempts, as well as timely referral for emergency care, and has been shown to help reduce the proportion of suicide reattempts among individuals recently discharged from hospital emergency departments (Vaiva et al., 2006).

Indeed, research suggests that people who have recently been discharged from hospital after treatment for mental illness may be at higher risk of suicide. According to a number of international studies (see Meehan et al., 2006; Goldacre et al., 1993; Geddes & Juszczak, 1995; Appleby et al., 2001; Yim et al., 2004), for those in contact with psychiatric services, the risk of suicide is at its highest during inpatient psychiatric care and the post-discharge period.

International studies have calculated rates of suicide death within 28 days of discharge as being between 2.9 and 4.3 suicide deaths per 1,000 discharges (NSW Mental Health Sentinel Events Review Committee, 2007; Appleby, 2000). For cases of post-discharge suicide, death has previously been estimated as being most frequent in the first two weeks after leaving hospital (Meehan et al., 2006). Others such as Hunt et al (2008) have suggested that the first week and the first day after discharge represent particularly high risk periods. Studies have demonstrated that long-term letter or postcard intervention can be effective in reducing repeat episodes of self-harm and also death by suicide among psychiatric inpatients refusing follow-up following discharge from hospital (see Carter et al., 2005; Motto & Bostrom, 2001; Royal Australian and New Zealand College of Psychiatrists Clinical Practice Guidelines Team for Deliberate Self-Harm, 2004).

Quite often, when individuals present with one or more mental disorders (in particular) the tendency among many (mental) health care professionals is to treat the illness rather than the person, and the social circumstances and life events that typically give manifestation to the development of such mental disorders remain unaddressed. The importance of effective clinical treatments (including antidepressant medications) should not be underestimated. However, SPA believes suicide prevention strategies should equally take account of interventions that aim to diminish and counteract life stress by addressing the range of social, situational, genetic, emotional and interpersonal factors that can give rise to the development of mental illness and/or suicide and suicidal behaviours.

As Goldney (2005, p. 130) points out, risk factors such as sexual abuse, parental domestic violence, and unemployment (often developed in childhood and adolescence and associated with adult mental disorders), among other social and situational risk factors (including, for example, the break down of relationships), should "demand the attention not only of health professionals, but of the community as a whole".

This rationale has been evident in a number of 'best practice' community intervention and outreach programs, such as (but not limited to) the following 'partnerships in action':

- The joint National Rugby League (NRL) *One Community* and Lifeline Australia *Help a mate stay in the game* campaign, which aims to reduce the incidence of suicide while increasing awareness of depression;

- The Prevention and Recovery Care (PARC) program in Victoria, designed to divert vulnerable mental health consumers from hospital ('step-up care') and provide support following discharge from hospital to promote recovery ('step-down care') and vocational rehabilitation outcomes; and

- The Mentally Healthy WA program, *ACT-BELONG-COMMIT*, aimed at promoting better mental health through the building of resilience, connectedness and wellbeing in a number of rural communities.

viii. Youth suicide (covered within pre-existing SPA Position Statements)

Within the school environment, a student's attempted, completed or suspected suicide is a similarly traumatic event. However, it can "also contribute to an increased risk of suicide in other vulnerable students and members of the student's family" (Department of Education and Children's Services et al., n.d).

In these instances, the role of schools and education providers to manage the (potentially long-term) impact of suicide on young people, including the tensions that inevitably arise from a duty of care to others and the ways in which information is shared between students, parents and staff following a student suicide, becomes vitally important; requiring great compassion, mindfulness and respect of the needs and wishes of the bereaved or affected family.

In spite of this, there generally appears to be a lack of understanding among Australia's school systems on confronting and dealing with critical incidents, such as adolescent and youth suicide and attempted suicide, and the impacts this can have on the broader school community (not least of all, the gossip and innuendo that can gather momentum in response to a lack of honesty about a death by suicide).

There are, of course, exceptions to this, as demonstrated by the joint production of suicide postvention guidelines and long-term critical incident strategies by educators and the government in South Australia (see Department of Education and Children's Services et al., n.d) and the work undertaken through the *MindMatters* national mental health initiative in secondary schools. These efforts are to be commended.

It is important to note that, in children, there are also some suggestions of a connection between being bullied, being a bully, and suicidal thoughts (Brunstein Klomek, Marrocco, Kleinman, Schonfeld, & Gould, 2007; Roland, 2002). The NSW Legislative Council General Purpose Standing Committee's final report into bullying of children and young people, released in November 2009, acknowledges this problematic relationship:

"This Inquiry clearly demonstrates that the NSW Department of Education and Training needs to take action to address bullying and cyber-bullying across the education system. The need for concerted efforts to address bullying is particularly important given the potentially tragic consequences of bullying, which in the most extreme cases can result in the loss of young lives to suicide."

-- Foreword from the final report, 'Inquiry into bullying of children and young people' (2009)

Among the report's findings was a trend towards the prevalence of cyber-bullying or rather the use of electronic communications tools, such as a mobile phone or computer, to bully and intimidate others – a form of bullying to which many students, parents and schools are especially struggling to respond (*Inquiry into bullying of children and young people*, 2009).

The report also found that schools were often overwhelmed by the number of anti-bullying programs available, some of which had not been properly evaluated. The report was critical of the absence of coordination between the state government's departments and agencies in the implementation of anti-bullying programs; particularly with regards to the lack of support and professional development to schools on cyber-bullying (*Inquiry into bullying of children and young people*, 2009).

Although no one method of intervention is most effective for all incidences of bullying, each type of intervention can be appropriate at different times and in different circumstances. Teachers need to be aware of the different methods of intervention, and trained in how to identify and implement the most appropriate intervention in a particular situation (*Inquiry into bullying of children and young people*, 2009).

A number of pertinent recommendations have emerged from the NSW Legislative Council General Purpose Standing Committee's report. SPA commends these to the Committee, highlighting in particular the following:

- Better assistance to schools in identifying evidence-based anti-bullying programs through the development of a blueprint program, established to provide schools with guidance on the research base and cost effectiveness of anti-bullying programs.
- Better training for teachers to ensure they are equipped with the knowledge and tools to prevent and intervene in incidents of bullying.
- That the NSW Department of Education and Training seek annual feedback from children and young people on anti-bullying initiatives implemented in their schools to ensure that anti-bullying initiatives are informed by, and respond to, the needs of children and young people.
- Development of a protocol for schools to report on their policies on bullying prevention and response, and their effectiveness.
- A greater research focus on cyber-bullying to increase understandings of the nature, causes and impact of cyber-bullying, and to identify the most effective means to address the emerging phenomenon.

More generally, there have also been a variety of effective programs developed in Australia and internationally that aim to enhance well-being and teach life skills, promote help-seeking, case-finding and referral, or tackle depression, substance misuse, conduct problems and/or suicidal behaviours among young people. SPA believes that there is value in identifying, reviewing and resourcing demonstrably effective programs for these challenges, with a view to explicitly examining and hopefully demonstrating their effective suicide prevention potential and disseminating them.

RECOMMENDATIONS – TOR f)

SPA strongly urges the Committee to review the recommendations specific to each high risk population group, as included in the SPA Position Statements, which are available for download from the SPA website (http://suicidepreventionaust.org/PositionStatements.aspx) or in hard copy format on request to SPA.

What follows is a selection of priority recommendations from each of the SPA Position Statements relevant to the role of targeted programs and services for high risk population groups, as required by TOR f).

1. Ensure widespread adoption by services of strategies already proven to enhance treatment adherence and/or to reduce suicide and self-harm following an attempt, such as continuing regular postcards, continuing brief intervention with contact, information and training sessions for staff and patients, and treatment adherence troubleshooting.

2. Improve responses to repeat and/or high lethality suicide attempters, and improved follow-up for psychiatric inpatients following discharge.

3. Systematically introduce a national community visitors program to ensure immediate and continuing engagement with consumers following discharge from emergency departments for suicide attempts and inpatient psychiatric hospitalisation.

4. Investigate the evidence contributing to the effectiveness and safety of first response teams.

5. Ensure improvements in access to hospitals and services and timely available interventions for individuals experiencing suicidal crisis.

6. Include families and friends (with the suicide attempt survivor's consent) in an individual's treatment and interventions.

7. Develop strategies and resources to assist family members and friends in understanding the suicidal state and supporting suicidal people.

8. There is a need for more rigorous monitoring of the incidence of suicide attempts.

9. Encourage greater identification and recognition of *suicide postvention* as a *suicide prevention strategy*.

10. Introduce mandatory suicide (and attempted suicide) postvention guidelines across all Australian educational institutions and schools, as well as initiatives that assist in improving the communication of grief, loss and suicide bereavement among children and adolescents.

11. Promote the potential benefits (and risks) of the internet and online social mediums as a non-confrontational means of support, particularly for at-risk and bereaved individuals who are geographically isolated or are seeking anonymity and privacy or 24-hour availability.

12. Develop a mentoring system for general practitioners, nurses, allied health and other support workers to enable regular debriefing during the establishment and implementation of suicide prevention strategies in rural and remote areas.

13. There is a need for better understanding of barriers to health care and mental health services, and the funding and development of alternative models that address these barriers (e.g. innovations in information technology, peer support and respite houses).

14. Introduce training for teachers and students to identify and respond to bullying and harassment, especially on the grounds of minority group membership generally, and sexual orientation and/or gender non-conformity specifically.

15. Develop a national anti-bullying campaign (similar to Australia's domestic violence campaign) focused particularly on bullying in schools and the workplace and on the grounds of gender and sexual orientation, and cyber-bullying.

16. Review and support demonstrably effective programs targeting depression, substance misuse and/or suicidal behaviours among young people, with a view to demonstrating and disseminating their effective suicide prevention potential.

g) The adequacy of the current program of research into suicide and suicide prevention, and the manner in which findings are disseminated to practitioners and incorporated into government policy

Research into suicide and suicide prevention not only provides evidence upon which to base potentially effective interventions, but can also play an important role in evaluating the efficacy of these interventions. However, in Australia, there is no clear set of priorities for this type of research and no systemic process for developing priorities (Robinson et al., 2008).

Internationally, much suicide research is devoted to epidemiology, but relatively little to interventions. This is further discussed below. Intervention studies are hard to mount at a population level, because of the difficulty in identifying valid control groups when the intervention involves the whole population or community. Ethical concerns arise with recruiting actively suicidal participants to intervention studies (e.g. antidepressant pharmacotherapy, psychotherapy) or alternatively excluding them from interventions (Jane Pirkis, personal communication). There are also major statistical problems with demonstrating a reduction of suicide, though these are not insurmountable (see below).

There is a manifest need to engage governments and other stakeholders in discussions with peak research funding bodies such as the National Health and Medical Research Council (NHMRC) and Australian Research Council (ARC) about prioritising the funding of suicide research; particularly intervention research. There is a vital role for academic institutions to be resourced to apply their expertise in researching suicide to the evaluation of projects funded through other sources (e.g. federal or state health departments). This could involve a program of mentoring those engaged in project and program evaluations to train such researchers and to develop a culture of successful evaluation that optimally takes place throughout the life of the project.

There may be value in also examining the effectiveness of competitive tendering for research funds, especially as it applies to funding based on needs, and the extent to which such tendering models promote collaboration between researchers and sector organisations in environments where there is a paucity of research funds (in this regard, different views were expressed by different stakeholders).

The incorporation of research findings (and also, more broadly, those of community consultations on suicide prevention) into Australian government policy has traditionally been poor, although more recently SPA has noted improved government engagement of non-government organisations and service providers (mostly in an advisory capacity) with regards to policy formulation and strategy development. This has been made apparent by the establishment of a National Centre of Excellence in Suicide Prevention, based at Griffith University, with the mandate of providing the Australian Government with advice to ensure suicide prevention initiatives are evidence-based and supportive of population groups who are at highest risk within the community.

There remains an imperative for vast improvements in the coordination and prioritisation of Australian research into suicide and suicide prevention research more generally, and the methods by which research findings are disseminated to practitioners and incorporated through collaborative and coordinated means into government policy. The dissemination and broader endorsement of Australian-based suicide prevention research has historically been inadequate.

i. Priority setting for research into suicide and suicide prevention in Australia

A recent empirical examination of priority setting in Australian suicide prevention research (see Robinson et al., 2008) identified that while journal articles have typically reported on studies of descriptive epidemiology, grants during the life of the *NSPS* (1999-2006) tended to fund intervention studies. Both gave equal weight to completed and attempted suicide, with little emphasis on studies of suicide methods. Young people were the most frequently researched group, with individuals with mental health problems and those who had attempted suicide or deliberately self-harmed also receiving attention (Robinson et al., 2008).

Researchers and other key stakeholders in the suicide prevention sector have typically expressed mixed views about the target groups that should be afforded priority in Australian suicide and suicide prevention research, although young people and people with mental illness were frequently ranked highly in the study by Robinson and colleagues (2008), as were men and older people in a qualitative report on the same study by Niner and associates (2009).

In Niner et al's report of research priorities, the need for greater emphasis on the evaluation of interventions was predominantly the most common issue raised across three group interviews with key suicide prevention sector stakeholders. Many participants in the interviews observed that while good epidemiological data exists on rates of suicide among particular population groups, and a reasonable amount of research has been conducted on risk and (to a lesser extent) protective factors, research into the efficacy of given interventions in the Australian context has been relatively neglected to date (Niner et al., 2009, p. 3). A number of participants suggested that funding for intervention programs should adopt a long-term approach and include a budget for evaluation and knowledge development, including education on the evaluation process for service providers (Niner et al., 2009, p. 3).

There is an argument to suggest that non-government organisations and suicide prevention advocates, such as SPA, may well also have a role to play in this *[as previously articulated in our response to TOR e)]* by more effectively disseminating the findings of their own research and member and community consultations (e.g. those conducted as part of the development of SPA Position Statements) on priority issues of suicide prevention, intervention and postvention to practitioners, government and service providers via face-to-face briefings. SPA currently distributes

the published version of its SPA Position Statements in both electronic and printed form to many of these stakeholder groups as well as others, notably mainstream media, both in advance of (under embargo) and subsequent to the public launch of each position statement. SPA Position Statements are also uploaded to the SPA website and referred to in the SPA quarterly e-newsletter.

Beyond specific interventions, however, participants in the aforementioned study also expressed the general view that critical examination of the service delivery system in Australia is required (Niner et al., 2009). "Mention was frequently made of the fact that many people who die by suicide receive services from different health and community services in the months, weeks and even days before death, often in relation to prior suicidal thoughts or behaviours". Participants noted that coordination between different sectors is sub-optimal, and that better communication between services may prevent some individuals from 'falling through the gaps' (Niner et al., 2009, p. 4).

SPA endorses the view that mapping these gaps may assist in better addressing them, and suggests this may be a project for which SPA, with appropriate resourcing, would be well placed to manage. We are also of the opinion that while research efforts need to be directed towards addressing the circumstances of those who do present to health and community services, equal attention must be afforded to those who *do not present*. Studies of the trajectory of suicidal behaviour via longitudinal methods may assist in this regard and provide clues to the ways in which services can be optimally responsive to at-risk individuals (Niner et al., 2009, p. 4).

In short, the literature indicates that, moving forward, Australia's suicide and suicide prevention research agenda should more effectively emphasise and adopt the principle and practice of evaluations of specific suicide-related interventions, policies, programs and services.

[Please note: The Committee may like to review these findings relative to those of an online survey of notable Australian suicide and suicide prevention researchers, conducted and published as part of the joint sector submission to the Senate Inquiry, 'Suicide is Preventable', of which SPA is a co-signatory, having jointly initiated its development with Lifeline Australia].

ii. Current knowledge and identifiable gaps in suicide prevention research specific to high risk population groups

There has been a paucity of evidence regarding what interventions work in suicide prevention. This is reflected in several systematic reviews of the evidence base of suicide prevention – e.g. Gunnell & Frankel's assessment of the relative poverty of evidence, published in the *British Medical Journal* (1994), and Mann et al's review (2005). Mann and colleagues, for example, identified restricting access to lethal means of suicide and educating physicians to detect, diagnose and manage depression as effective strategies. While not rejecting other strategies as ineffective, they did not find sufficient numbers of high calibre studies examining other approaches to confirm their efficacy.

Recent effective strategies have emerged, however, that could have universal application. For example, randomised controlled trials (the highest form of evidence of effectiveness) have indicated that continuing support after hospitalisation can prevent suicide. In the United States, Motto & Bostrom (2001) studied psychiatric inpatients that had refused follow-up, using postcards inviting them to stay in touch at regular intervals. A subsequent World Health Organization multi-country study of suicide attempters (see Fleischmann et al., 2008) used regular phone calls or visits to do the same. Carter and colleagues (2005) have demonstrated something similar for self-harm.

These are relatively inexpensive interventions that work by enhancing social connectedness and sense of personal value. Allowing for appropriate cultural adaptations, such interventions could be costed and considered for application in Australian emergency departments and psychiatric wards post-discharge. There is also emerging international evidence that points to other effective suicide prevention programs (e.g. from the Suicide Prevention Resource Center in the United States in relation to US-based programs) concerning interventions that work. A recent study in the United States, for example, found that, from analyses of responses provided by mental health consumers, the top three coping strategies for people at-risk of suicide and with a history of attempted suicide include: religious/spiritual beliefs and practices, companionship, and positive thinking encouraged by a social network of family and peers (Alexander et al., 2009).

All of this evidence should be systematically reviewed for its effectiveness and applicability in the Australian context. Some evaluative work of this nature has already commenced in relation to eHealth treatment programs and services in Australia (e.g. McCrone et al., 2004; Christensen & Griffiths, 2007; Shandley et al., under review).

[The joint sector submission to the Senate Inquiry, 'Suicide is Preventable', addresses many of these issues in greater detail and SPA refers the Committee to this document for further reading].

Despite this, a recurring theme throughout the reference group and community consultations conducted in the development of SPA Position Statements has been the identifiable gaps in suicide and suicide prevention research in Australia, specific to high risk population groups.

A selected summary of a number of these issues, which stakeholders have previously identified as being under-researched areas of knowledge and understanding, has been extracted from SPA's series of published position statements and is included for ease of reference below for the Committee's consideration.

[Please note: A number of the issues included below have been explored in greater detail elsewhere in this submission in SPA's responses to other TOR outlined by the Committee].

Significant gaps in suicide and suicide prevention research, specific to high risk population groups and as identified through SPA community consultations include, but are not necessarily limited to:

- The personal impact on professionals following a patient's suicide, particularly in instances where a bereaved family feels aggrieved by a perceived failure of (mental) health care and treatment.
- The increased risk and impact of vicarious trauma to which first responders to suicide and suicidal crisis may be subject, in addition to volunteers of suicide bereavement support groups and services, work colleagues and associates, and communities more generally.
- Quantification of the impact and economic cost of suicide and self-harm to the Australian community.
- Evaluation and review of suicide deaths and suicide attempts by persons refused admission whilst in psychiatric care and following hospital discharge.
- The practice of detention and seclusion within mental health facilities and the extent to which it is compatible with human rights instruments, effective suicide prevention and care standards, and proven practice in promoting engagement and minimising treatment refusal and coercion.
- The extent to which inadequacies in assessment and response to people at-risk of suicide contribute to death by suicide.
- The adequacy of current prevention and intervention strategies, programs and services for child abuse, neglect and trauma, and bullying, given what is known of the developmental impact of these on later suicide rates.
- The effectiveness of antidepressants as a suicide prevention strategy in Australia.
- The use of new media and the internet as avenues for suicide prevention and postvention information, support and resources.
- Widespread dissemination of findings resulting from the ongoing evaluation of the *Mindframe* principles, and the impact of voluntary regulatory codes on the reporting practices adopted by mainstream media coverage of suicide, self-harm and mental illness.
- The impact of global large-scale events (e.g. the global recession, climate change) on suicide rates and the extent to which these are being prioritised and responded to in suicide prevention thinking.
- The precise relationship between unemployment (and economic disadvantage) and suicide.
- Attitudes relating to suicide and suicidal behaviours, stigma and related help-seeking among the general public, (mental) health professionals, and those with lived experience.

In addition, SPA strongly believes that greater emphasis should be placed on the consideration of *protective factors* in relation to suicide and suicide attempts, in conjunction with the traditional examination of *risk factors*. A much deeper understanding is required of people's capacity for resilience and optimism and the ways in which we might better develop pathways to hope and social cohesion in society. This process may, for instance, entail an analysis of different levels of resilience in different communities, and an examination of why individuals in similar circumstances respond to traumatic and challenging events with different levels of optimism (Niner et al., 2009, p. 6).

iii. Bridging the gap between empirical research and experience

The majority of suicide and suicide prevention research in Australia has traditionally focused on risk factors and quantitative data, which has undoubtedly helped guide clinical interventions. However, there is currently little information about lived experience from those affected by suicide and those who provide services for them, or equally, understandings of internal suicidal processes (Michel et al., 2009; Niner et al., 2009). As Webb (2006, p. 16) notes, "for a more complete understanding of suicidality we need to bridge the "explanatory" gap between first-person, subjective experience and third person, objective knowledge."

[As we have previously emphasised in the introductory section to this submission, SPA believes it is crucial that the diversity of voices and experiences of suicide attempt survivors and bereaved individuals are represented in these narratives].

A report published following SPA's National Conference in 2004, *Closing the Gap*, endorses a number of these views in its summary of recommendations to which presenters and delegates were asked to contribute with a view to the future direction of strategies in suicide prevention in Australia. Among the recommendations is a call for greater capacity among the research community to broaden the evidence base in suicide prevention and diminish the gap between empirical research and 'real world' application – translating research findings into practice by, for example, ensuring

rigorous evaluations are conducted alongside funded service delivery projects to measure and provide evidence of effectiveness. There is also a need to communicate research findings to stakeholders in meaningful ways that encourage individuals to become "effective community agents in the area of suicide prevention"; raising the profile of suicide as a social issue (Niner et al., 2009, p. 6).

The mainstream and online media have the capacity to contribute meaningfully to this. Although, SPA acknowledges "the need to conduct media campaigns and related activities with caution, given the strong evidence that reporting of suicide can lead to copycat behaviours" and the need for media activities themselves to be closely evaluated against the various guidelines, including the principles of the *Mindframe National Media Initiative in Australia*, issued on the accurate portrayal of suicide and self-harm in the media (Niner et al., 2009, p. 7).

There is evidence to suggest that the number and quality of media reports has increased as a result of the introduction of such guidelines (Pirkis et al., 2009). Their aim to encourage responsible reporting of suicide is thus confirmed, and research has shown that, quantitatively, reports of this kind have increased. However, questions still remain regarding whether there is also some avoidance of reporting of suicide that prevents the possible range and intensity of stories of suicide being covered, and which inhibits public discussion, acknowledgement and appropriate collective action.

> *"After encountering suicides professionally and personally over many years, I have come to the conclusion that the reporting guidelines promote rather than prevent suicides…Suicides in our circulation area are sometimes very public and very visible. It goes against all our instincts to pretend they have not happened…I would ask the Senate to take a completely fresh look at the cloistered world of suicide reporting – where police, the coroner, mental health professionals and amateurs, and the mainstream media, all conspire to make friends and relatives feel they are part of something so unutterably shameful that it can only be whispered about among members of a closed circle".*
>
> ***-- Personal story submitted to SPA by a suburban newspaper editor/proprietor, Submission 091***

Just as there should be a multidisciplinary approach to service delivery and responses to at-risk individuals, so too should this be the case with regards to suicide prevention research and policy development; recognising that suicide is not (only) a health problem.

RECOMMENDATIONS – TOR g)

1. Engage governments, peak research funding bodies such as the NHMRC and ARC, the Centre for Excellence in Suicide Prevention, and other stakeholders in discussions to develop a national suicide and suicide prevention research agenda in Australia, and to improve funding and systematic review of priority-setting for Australian research in the field of suicide prevention and intervention (with particular attention to intervention research).

2. Encourage a broadening of the evidence base to diminish the gap between empirical research and 'real world' application (e.g. incorporating the lived experiences of suicide attempt survivors and bereaved individuals).

3. To ensure evidence of effectiveness, establish partnerships between universities, and government, philanthropic and business organisations, to apply academic expertise to the evaluation of service delivery and related projects throughout the life of projects.

4. Initiate mentoring programs for those engaged in project and program evaluations, to train researchers and to develop successful cultures of evaluation.

5. Examine the effectiveness of competitive tendering for research funds, especially as it applies to funding based on needs, and the extent to which it promotes collaboration between researchers and sector organisations in environments where there is a paucity of research funds.

6. Conduct a comprehensive evaluation of suicide prevention policies, programs and services in Australia, and ensure suicide-related research continues to focus on attempted suicide as well as completed suicide.

7. Ensure intervention studies and epidemiological studies of risk and protective factors and people's capacity for resilience are made priorities of the national research agenda.

8. Undertake a systematic review of international interventions to assess effectiveness, costing and applicability in Australian emergency departments and psychiatric wards post-discharge.

9. Address the 'gaps' in current suicide-related research, as outlined in the body of SPA's response to TOR g), by including these as priorities on the national research agenda.

10. Direct research efforts towards addressing the circumstances of those who do not present to health and community services, as well as those who do, to inform targeted help-seeking initiatives for individuals at risk of suicide and to ensure services are optimally responsive.

11. Improve the methods by which research findings are disseminated to practitioners and incorporated through collaborative and coordinated means into government policy.

12. Communicate research findings to stakeholders in meaningful ways that encourage individuals to become "effective community agents in the area of suicide prevention"; raising the profile of suicide as a social issue.

h) The effectiveness of the *National Suicide Prevention Strategy* in achieving its aims and objectives, and any barriers to its progress

The origins of the *National Suicide Prevention Strategy (NSPS)* date back to 1999 when the strategy was first established by the Australian Government. Responsibility for the *NSPS* was given to the Department of Health and Ageing (DoHA), which still retains oversight of the policy framework today. The *NSPS* is guided by the *Living Is For Everyone (LIFE) Framework,* which sets out the national priorities for suicide and self-harm prevention in Australia.

In 2005-06, Urbis Keys Young completed an evaluation of the *NSPS*, concluding, among its findings, that:

- Most gains in the *NSPS* investments to the end of 2005 occurred in relation to capacity building at individual and service level, including both increased networks and access to support and resources;
- The governance arrangements for the *NSPS* were complex and in need of review;
- Funding decisions needed to be based on needs (e.g. suicide rates and local issues) rather than be demand or application driven;
- There was little evidence to show that projects under the *NSPS* reduced suicide or self-harming behaviours; and
- The *NSPS* would benefit from more specific goals and objectives (including clearer linkage with other larger programs such as mental health strategy), a more effective evaluation framework, a comprehensive research agenda, streamlined governance, and strengthening of program information systems.

(ConNetica Consulting for the Suicide Prevention Taskforce and SPA, 2009)

Following the Urbis Keys Young evaluation, DoHA commenced a major revision of the *LIFE Framework* in late 2006. This was completed by the consultants in July 2007 following extensive stakeholder consultations. Regrettably, the Urbis Keys Young report was not released until April 2009, well after the subsequent review of the *LIFE Framework* was complete.

In October 2007, one of three elements of the revised *LIFE Framework* documents was released by the Hon. Senator Brett Mason, then Parliamentary Secretary. This document was placed on the DoHA website, but was not published in print form. The document differed significantly from that completed by the consultants and was never subject to stakeholder review or comment. The revised *LIFE Framework* and related documents under the *LIFE Framework*, namely *Research and Evidence in Suicide Prevention* and *Practical Resources for Suicide Prevention*, were released in July 2008 (ConNetica Consulting for the Suicide Prevention Taskforce and SPA, 2009).

It is under the auspices of and within the objectives established by this most recent document that SPA has been required to manage its ongoing advocacy work and activities. The revised *LIFE Framework* is available online at: www.livingisforeveryone.com.au

[The 'Let's Get Serious: The Infrastructure to Effectively Address Suicide in Australia – A Submission to the Senate Community Affairs Committee Inquiry on Suicide in Australia' concept paper prepared by ConNetica Consulting for the Suicide Prevention Taskforce and SPA covers the context to the NSPS in greater detail].

i. Evaluating the effectiveness of the current NSPS and policy framework

The primary objective of the current *NSPS* is to reduce deaths by suicide and reduce suicidal behaviour by:

- Adopting a whole-of-community approach to suicide prevention to extend and enhance public understanding of suicide and its causes; and
- Increasing support and care available to people, families and communities affected by suicide or suicidal behaviour by providing better support systems.

(Australian Government, online, updated 15 September 2009)

Historically, evaluations of the *NSPS* (in its previous incarnations) have demonstrated broad support for the strategy's objectives. 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 (ConNetica Consulting, SPA Evaluation, 2008).

At the time of the organisational review of SPA (early 2008), which considered the modus operandi of suicide prevention programs under the previous Federal government, some government departments were perceived to be acting unilaterally. For example, DoHA's refusal to provide the National Advisory Committee on Suicide Prevention (NACSP) with the independent evaluation report on the *NSPS* and the *LIFE Framework* (completed by Urbis Keys Young) was seen to be strategically unfortunate. Other major review outcomes, such as that of the *National Activities on Suicide Bereavement* (2006), were also withheld from public release, including to the consortium that had originally undertaken the work.

Questions were also raised by some SPA members and segments of the suicide prevention sector over the independence of service providers appointed to manage portfolios such as the communications strategy for the *LIFE Framework*. These decisions prompted various concerns among members and within the suicide prevention sector as to the political transparency of policy formulation and tendering processes, and the broader capacity of government to advance the objectives of the *NSPS*.

In spite of such concerns, a great deal has already been achieved by the *NSPS* (though it must be acknowledged that the paucity of evaluation of interventions in Australia does make drawing any firm conclusions about the efficacy of the *NSPS* somewhat problematic). A number of recent developments and achievements, including effective suicide awareness campaigns and prevention programs, have previously been highlighted in the introductory section to this submission.

In line with the *LIFE Framework*, a broad range of national projects has been initiated, taking a community capacity building approach to suicide prevention. Over 150 community projects have been funded across the states and territories with an additional 27 national projects funded during the first phase of the *NSPS* (1999-2006). Most of the community projects were one off grants for small-scale projects (ConNetica Consulting for the Suicide Prevention Taskforce and SPA, 2009).

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 (Urbis Keys Young, 2006). The ability to build a sound body of evidence through research and baseline data has potentially frustrated the objectives of the *NSPS*. These views have elsewhere been expressed by others involved in the sector, suggesting that although the *NSPS* grants funded for projects and fellowships related to suicide prevention have not been insignificant, they remain incommensurate with the high individual, societal and economic burden of suicide and suicidal behaviours in Australia (Robinson et al., 2008) and may benefit from some revision.

Currently, there are major reforms of the health system being canvassed in the Australian community. The Australian Government is placing increased emphasis on the need to re-balance our health system with a greater focus on prevention and early intervention. New financing mechanisms, new structures and governance arrangements are being considered. In relation to suicide prevention, the Suicide Prevention Taskforce and SPA believe new structures need to be developed or re-positioned towards:

- Raising and distributing funding – from across the community from a wide variety of sources;
- Structures for governance and accountability need to be established – potentially independent of government and service agencies; and
- Service delivery, capacity building, community awareness and education, and advocacy need to be appropriately resourced and not reliant on ad hoc funding arrangements.

(ConNetica Consulting for the Suicide Prevention Taskforce and SPA, 2009)

As a means of reducing the overall personal, social and economic impacts and costs of suicide and suicidal behaviour on the Australian community, SPA urges the Australian Government to also consider at least doubling its current expenditure ($22.1 million in 2009-10) in relation to the funding of Australian-based suicide prevention initiatives and evidence-based research, including randomised controlled trials and costings of interventions. A move away from a short-term approach towards project funding in preference of longer-term investment, a sound body of evidence through baseline data, and a renewed commitment to developing a more collaborative, coordinated and integrated multidisciplinary response to suicide and self-harm in Australia are also strongly encouraged.

ii. Recent developments and potential barriers to progress

SPA and its members have been encouraged by more recent improvements in the cooperation between the *NSPS* and state-based suicide prevention strategies, although there remain some limits to this collaboration and an opportunity for further improvement. The current Australian Government's establishment of an Australian Suicide Prevention Advisory Council (ASPAC) has generated renewed sector enthusiasm towards and confidence in the workplan of the *NSPS*, which now appears to have a stronger emphasis on:

- Selective interventions for high risk groups;
- Service provision through better coordination and streamlined referral pathways, known as "safety nets";
- Collaboration and joint planning with the states and territories and community organisations; and

- Strengthening the evidence base, including funding for the Australian Centre for Suicide Prevention and Research (AISRAP).

The relationship between government and ASPAC has been noted as being more collaborative and receptive than previous government engagements with expert advisory panels may have possibly been, and this has been seen by many SPA members and sector stakeholders as a particularly encouraging development.

As reiterated in TOR g), some potential barriers to progress of the *NSPS* persist, including the predilection towards competitive tendering for research funds, which has the potential to discourage much-needed collaboration between researchers and sector organisations. A mapping exercise to collect, by postcode, ABS/NCIS data on suicides in addition to self-harm and service provision data to assist in advocating funding priorities determined by geographic need rather than those based simply on competitive tendering has elsewhere been proposed by SPA *[see response to TOR a)]*.

The 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. These legacy issues remain an ongoing challenge for the current Australian Government to overcome in relation to the continuous improvement of the *NSPS*.

RECOMMENDATIONS – TOR h)

1. Establish structures of governance and accountability in the suicide prevention sector that are potentially independent of government and service agencies.
2. Ensure ongoing transparency of policy formulation and tendering processes related to the *NSPS*.
3. Ensure funding of suicide prevention projects is commensurate with the social and economic costs of suicide on the Australian community.
4. Broaden the funding base for suicide prevention projects and interventions by raising and distributing funding from across the community and from a wide variety of sources.
5. Service delivery, capacity building, community awareness and education, and advocacy need to be appropriately resourced and not reliant on ad hoc funding arrangements.
6. Consider doubling current government expenditure on national suicide prevention projects in Australia.
7. Shift funding priorities 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*.
8. Continue to improve collaboration and joint planning between national and state/territory suicide prevention strategies and projects, as well as between the states and territories and community organisations.

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SPA Position Statements

- Supporting Suicide Attempt Survivors (September 2009)
- Suicide and self-harm among Gay, Lesbian, Bisexual and Transgender communities (August 2009)
- Mental Illness and Suicide (June 2009)
- Suicide Bereavement and Postvention (May 2009)
- Responding to suicide in rural Australia (September 2008)
- Men and Suicide: Future Directions (April 2008)
- Suicide Prevention and Capacity Building in Australian Indigenous Communities (April 2008)

Available online: http://suicidepreventionaust.org/PositionStatements.aspx

Appendix A
List of Memberships

Suicide Prevention Taskforce Membership

Dr Michael Dudley, Suicide Prevention Australia

Dawn O'Neil AM, Lifeline Australia

Jill Chapman, MOSH Australia

Louise Duff, Brilliant Logic Pty Ltd

Kerry Graham, Inspire Foundation

Wayne Koivo AM, Former Member of NACSP

Ryan McGlaughlin, Suicide Prevention Australia

Adjunct Professor John Mendoza, ConNetica Consulting Pty Ltd

SPA Position Statement Reference Groups

Supporting Suicide Attempt Survivors (September 2009)

This position statement was launched at the SPA Community Forum in Perth on World Suicide Prevention Day, 10 September 2009, by Ms Allison Kokany, Chairperson, NSW Consumer Advisory Group, Mental Health Inc, and Dr Michael Dudley, Chairperson, Suicide Prevention Australia and Member of the Australian Suicide Prevention Advisory Council.

Members of the Reference Group for this position statement were:

Dr Michael Dudley, Suicide Prevention Australia (Co-Chair)

Allison Kokany, NSW Consumer Advisory Group, Mental Health Inc. (Co-Chair)

Susan Beaton, Lifeline Australia

Carol Bennett, Consumer Health Forum of Australia

Dr Jane Burns, Inspire Foundation and VicHealth

Graeme Cowan, Author "Back from the Brink"

Kathleen Ellerman-Bull, BoysTown and Kids Help Line

Barbara Hocking, SANE Australia

Ryan McGlaughlin, Suicide Prevention Australia

Ingrid Ozols, mh@work

Associate Professor Jane Pirkis, School of Population Health, Melbourne University

Jo Robinson, ORYGEN Research Centre

Chris Smith, Hunter New England Area Health Service

Margaret Springgay, Mental Illness Fellowship of Australia

Alan Woodward, Lifeline Australia

Dr Marianne Wyder (Writer and Researcher)

Suicide and self-harm among Gay, Lesbian, Bisexual and Transgender communities (August 2009)

The position statement was launched on 31 August 2009, by the Hon. Michael Kirby AC CMG (Retired Justice of the High Court of Australia).

Members of the Reference Group for this position statement were:

Dr Michael Dudley, Suicide Prevention Australia (Co-Chair)

Associate Professor Anne Mitchell, Australian Research Centre in Sex, Health and Society, La Trobe University and Gay and Lesbian Health, Victoria (Co-Chair)

Susan Beaton, Lifeline Australia

Judy Brown, Parents and Friends of Lesbians And Gays (NSW)

Jo Harrison, University of South Australia and Gay and Lesbian Ageing Network

Dr Lynne Hillier, Australian Research Centre in Sex Health & Society, La Trobe University

Aram Hosie, WA Gender Project

Dr John Howard, National Drug and Alcohol Research Centre

Terrence Humphries, Twenty10 GLBT Youth Support and Gay & Lesbian Counseling Service (NSW)

Ryan McGlaughlin, Suicide Prevention Australia

Sally Morris, Open Doors (QLBT Youth Service)

Jonathan Nicholas, Inspire Foundation

Lindsay Osborne, Aboriginal Health Division, Department of Health, South Australian Government, AIDS Council of South Australia, and Gay and Lesbian Ministerial Advisory Council, SA

Dr Garrett Prestage, National Centre in HIV Epidemiology and Clinical Research, Faculty of Medicine, University of NSW

Rebecca Reynolds, Twenty 10 GLBT Youth Support

David Scamell, National LGBT Health Alliance and AIDS Council of New South Wales

Dani Wright, Freedom Centre and WA AIDS Council

Atari Metcalf, Inspire Foundation (Writer and Researcher)

Mental Illness and Suicide (June 2009)

This position statement was launched at the *LIFE Awards* on 11 September 2009, by Professor Rob Donovan, Professor of Behavioural Research, Faculty of Health Sciences, Curtin University and Principal of Mentally Healthy WA's *Act-Belong-Commit* Mental Health Promotion Campaign.

Members of the Reference Group for this position statement were:

Dr Michael Dudley, Suicide Prevention Australia (Co-Chair)

Adjunct Professor John Mendoza, National Advisory Council on Mental Health (Co-Chair)

Susan Beaton, Lifeline Australia

Dr Peggy Brown, Mental Health, ACT Government

Dr Jane Burns, Inspire Foundation

Professor Peter Bycroft, Corporate Diagnostics

Professor Diego De Leo, Australian Institute for Suicide Research and Prevention, Griffith University

Professor Rob Donovan, Centre for Behavioural Research in Cancer Control, Curtin University of Technology

Jill Fisher, United Synergies, StandBy Response Service

Professor Robert Goldney, University of Adelaide

Barbara Hocking, SANE Australia

Professor Graham Martin, University of Queensland

Ryan McGlaughlin, Suicide Prevention Australia

Associate Professor Jane Pirkis, Centre for Health Policy, Programs and Economics, Melbourne University

Jane Westley, Australian General Practice Network

Katrina Clifford (Writer and Researcher)

Suicide Bereavement and Postvention (May 2009)

The position statement was launched at the 2nd Australian Postvention Conference in Melbourne on 22 May 2009, by international guest speaker, Dr Kari Dyregrov, from the University of Bergen, Norway.

Members of the Reference Group for this position statement were:

Dr Michael Dudley, Suicide Prevention Australia (Co-Chair)

Jill Fisher, United Synergies, StandBy Response Service (Co-Chair)

Envoy Alan Staines, The Salvation Army Suicide Prevention Bereavement Support Services

Connie Alomes, Hobart Lifeline

Susan Beaton, Lifeline Australia

Jill Chapman, Bereaved Through Suicide Support Group

Linda Espie, Director CISM & L M Espie Counselling and Consultancy

Louise Flynn, Jesuit Social Services Support After Suicide

Sharon Hillman, ARBOR

Dr Helen Klieve, Queensland Suicide Register

Ryan McGlaughlin, Suicide Prevention Australia

Mary Parsissons, Lifeline Australia

Dr Diana Sands, Bereaved by Suicide Service Chatswood

Katrina Clifford (Writer and Researcher)

Responding to suicide in rural Australia (September 2008)

This position statement was launched at the *LIFE Awards* on 10 September 2008, by Dr Michael Dudley, Chairperson, Suicide Prevention Australia, and Ms Lexia Smallwood, Policy Advisor, National Rural Health Alliance.

Members of the Reference Group for this position statement were:

Dr Michael Dudley, Suicide Prevention Australia (Co-Chair)

Gordon Gregory, National Rural Health Alliance (Co-Chair)

Lexia Smallwood, National Rural Health Alliance

Dr John Ashfield, Lower Eyre Health Services

Brian Egan, Aussie Helpers

Martin Harris, University of Tasmania

Gaynor Hicks, LivingWorks Australia

Professor Brian Kelly, Centre for Rural and Remote Mental Health

Julian Krieg, Kondinin Group

Ryan McGlaughlin, Suicide Prevention Australia

Andy Nielsen, Fred Hollows Foundation

Trudy Pregnall

Professor Cath Rogers-Clark, University of Southern Queensland

Nick Tolhurst, beyondblue

Robert Williams, Royal Flying Doctors Association of Australia

Lesley Young, CWA

Katrina Clifford (Writer and Researcher)

Men and Suicide: Future Directions (April 2008)

This position statement was launched on 13 April 2008, by Dr Michael Dudley, Chairperson, Suicide Prevention Australia, and Professor John Macdonald, Men's Health Information and Resource Centre.

Members of the Reference Group for this position statement were:

Dr Michael Dudley, Suicide Prevention Australia (Co-Chair)

Professor John Macdonald, Men's Health Information and Resource Centre (Co-Chair)

Gary Bryant, Men's Advisory Network

Professor Peter Bycroft, Corporate Diagnostics Pty Ltd

Tim Corney, Incolink

Dr Nicholas Foster, Mensline Australia

Peter Gebert, cbus

Stephen Kilkeary, Centacare Sydney

Ryan McGlaughlin, Suicide Prevention Australia

Terry Melvin

John Mendoza

Shawn Phillips, WA Ministerial Council of Suicide Prevention

Anthony Smith

Keith Todd, OzHelp Foundation

Nick Tolhurst, beyondblue

Katrina Clifford (Writer and Researcher)

Suicide Prevention and Capacity Building in Australian Indigenous Communities (April 2008)

This position statement was launched on 13 April 2008, by Dr Michael Dudley, Chairperson, Suicide Prevention Australia, and Dr Mick Adams, Chair of both the National Aboriginal Community Controlled Health Organisation and SPA's Indigenous Gathering Committee.

Members of the Reference Group for this position statement were:

Dr Michael Dudley, Suicide Prevention Australia (Co-Chair)

Dr Mick Adams, National Aboriginal Community Controlled Health Organisation (Co-Chair)

Tom Brideson, Charles Sturt University Raymond Campbell

Bonny Gibson

Kate Gilbert, Office for Aboriginal and Torres Strait Islander Health, Australian Government Department of Health and Ageing

Professor Ernest Hunter, Queensland Health and University of Queensland

Christine King, Indigenous Practice and Coordination, Office for Children, Youth and Family Support, ACT Government

Ryan McGlaughlin, Suicide Prevention Australia

Dr Tracey Westerman, Indigenous Psychological Services

Katrina Clifford (Writer and Researcher)

Suicide Prevention Australia (SPA) Membership

SPA's members play a vital role in fulfilling the organisation's key advocacy role, and help ensure representation of the diverse experiences and views of Australians. All SPA members add their voice to our organisation and help strengthen our response to suicide prevention, intervention and postvention.

The following members of SPA have given permission for their name to be published in this submission:

Organisational Members

Care for Life: Suicide Prevention Assoc. Inc (Raylee Taylor)

Jesuit Social Services, Support After Suicide

Lifeline South West VIC

Maitland Region Suicide Prevention Network

Mental Health Association NSW

Mental Health First Aid Training and Research Program

Orange Region Suicide Prevention Network

Port Stephens Suicide Prevention Network

Rural Alive & Well Inc Tasmania (Vyv Alomes)

Samaritans Crisis Line

School of Health, University of New England

Semmens Executive Recruitment

[For privacy reasons, the name of 49 organisations with SPA membership has been withheld].

Individual Members

Caroline Aebersold

Jean-Claude Boulenaz

Dagmar Ceramidas

Jill Chapman

Louise Curtis

Professor Brian Draper

Dr Michael Dudley

Professor Robert Goldney

Leonore Hanssens

Martin Harris

Ann-Maree Hartley

Penelope Hasking

Jenni Hearn

Kirsty Kriss

Len Matthews

Mandy Meredith

Dr Keith Miller

Tony Miller

Dr Nick O'Connor

Elizabeth Percy

Shawn Phillips

Hugh Rawling

Steve Richards

Joanne Riley

Marie-Louise Riley

Dr Maria Scoda

Jenny Slape

Anthony Smith

Envoy Alan Staines OAM

Lois Staines

Sam Strecker

Jenn Tranter

Dr Mardie Whitla

[For privacy reasons, the name of 49 individuals with SPA membership has been withheld].

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