Senate Community Affairs Committee

Inquiry into Suicide in Australia

The Salvation Army

Submission

Prepared on behalf of
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Executive Summary

The Salvation Army appreciates the opportunity to provide a response to the Senate Community Affairs Committee, Inquiry into Suicide in Australia. This submission draws on the experience of Salvation Army social service centres, Salvation Army suicide prevention and postvention programs, telephone counselling services, feedback received from Salvation Army Officers and employees about their experiences in working with people affected by suicide and most importantly we sought comments from many families who have been involved with Salvation Army Bereavement Support Programs and those who were involved in the Life Keeper Quilt Project.

The Salvation Army affirms the dignity and worth of all human beings and we value each life. However we also understand the sense of hopelessness and despair which leads people to feel that their only choice is to end their life. It is our contention that people who complete suicide, don't want to die, they primarily want the pain to stop.

The Salvation Army encounters people in deep distress, in our work throughout Australia, some of these people are homeless, some have serious financial issues, some are struggling with addictions, some have been diagnosed with mental illness, some are experiencing a sense of loss, loss of a loved one, loss of a job, loss of health and many have lost all **hope**. Many of these people are 'at risk' of suicide and we believe that we need to raise awareness throughout the community of the issues impacting upon individuals and families and more critically; - how we can each intervene to assist people to get the support they need.

The Salvation Army recently commissioned Roy Morgan Research to conduct a nation wide survey into awareness of suicide amongst the Australian community. The result of the survey demonstrates that awareness of the number of people who are recorded as dying by suicide each year in Australia is low, with only 14% of Australians indicating that they knew the number.

Whilst we recognise that much has been done in the past 15 years, to raise the level of awareness about suicide, much more needs to be done. Furthermore we need to ensure that targeted programs are developed and adequately funded to provide appropriate, timely and sensitive support to people who are at risk of suicide and those who have been bereaved by suicide.

The Salvation Army makes the following recommendations to address some of the key concerns that have emerged from our work with people who are at risk of suicide, those who have attempted suicide and with individual and families who have lost a loved one by suicide.

Recommendations

1. **Promote the value of life for everyone and raise community awareness of the resources and information provided through the Living is for Everyone (LiFE) Framework.**

2. **Develop public awareness campaigns to educate the public about myths and warning signs of people who are suicidal.**

3. **Develop specific resources to help to inform parents about the issues of suicide and how to refer their children to appropriate support.**

4. **Continue to raise awareness around the issue of mental illness to educate the public on how to support people with mental illness.**

5. **Provide additional resourcing for Bereavement Support Training, recognising that suicide postvention can also be suicide prevention.**

6. **Provide specific training and support to members of the Clergy as potential first response support teams alongside police and emergency services.**

7. **Promote web based training courses on suicide prevention of suicide, recognising the wide accessibility of the internet and the ability to reach people in remote locations and those who may be reluctant to undertake face to face training.**

8. **Resource homelessness and AOD services to develop capacity building and resilience programs to support people who are socially isolated and/or disconnected young people who have limited family or personal support networks.**

9. **Develop suicide prevention and support programs which focus on provision of support to elderly people.**

10. **Develop better connections and protocols between hospital health workers and the mental health teams in providing 'wrap around supports' to people who are feeling suicidal.**

11. **Provide avenues for Mental Health Advocacy groups to recommend and implement changes in the mental health system in response to client needs.**

12. **Ensure that specialist beds are available to enable the hospitalisation of people who are feeling suicidal so the person can be observed and monitored.**

13. **Work on improving the practice standards of the Risk Assessment when people enter the Emergency Department following a suicide attempt to avoid the possibility that suicidal people might be able to anticipate the perceived correct answers which ensures an immediate discharge from hospital.**

14. **Ensure that the Suicide Risk Assessment conducted in Emergency Departments also examines the physical, emotional and social supports available to the individual. i.e. if the person is homeless or living alone, ensure that social welfare agencies or church groups are contacted and resourced to provide additional support to people on discharge.**

15. **Ensure that adequate support is provided to people who are discharged from hospital following a suicide attempt. A Hospital Discharge Case Plan should be developed that would provide intensive support following discharge that would progressively by withdrawn as the episode passes. The support plan could include family and friends and would mean that the individual could leave hospital and return to a more "natural" environment. Funding should be provided for 'support persons' to be available 24/7, immediately following discharge.**

16. **Pilot a 'Care House' initiative to provide a supported and caring environment for people who are homeless or living alone, who are discharged from hospital following a suicide attempt.**

17. **Develop and fund early intervention programmes for teenagers and school children which focus on the value of life, peer support, self soothing and resilience.**

18. **Ensure that joint protocols are developed between mental health services and community support services.**

19. **Facilitate home visits by Mental Health Team workers for people discharged from mental health units, to assess progress and ensure that people are taking appropriate medication**

20. **Fund specific programs which focus on creative and fun activities which provide people with an opportunity to socialise especially during difficult times. Recreation and social activities play an important part in helping people through periods of mental and emotional crisis.**

21. **Implement drug and health education harm minimisation programs that encourage a young person to stay safe, until such time as they are ready to address their particular issues.**

Introduction

The Salvation Army has been providing a wide range of community services to disadvantaged people in the Australian community for over 100 years. Salvation Army services operating in over 900 centres across Australia provide counselling and active practical support designed to meet the needs of people who are alienated in society because of poverty, homelessness, health issues, dependency issues, unemployment and/or experiencing personal crisis.

The Salvation Army is committed to providing timely, effective, unconditional and compassionate services to meet the needs of those within our community who are lonely, alienated or experiencing hardship.

Many of those people that The Salvation Army assists are affected by mental illness and significant numbers face situations that lead them to contemplate and attempt suicide. Our work also brings us in regular contact with members of the Australian community whose lives have been devastated by the suicide of someone close to them.

The Salvation Army Work in Suicide Prevention & Bereavement Support

The Salvation Army, first began its work in suicide prevention in 1907 and established anti suicide bureaus in Sydney, Melbourne, Brisbane, Adelaide and Perth. The organisation was one of the first in the world to establish suicide prevention programs, beginning in London responding to what a newspaper article called 'suicide mania' which had gripped London at the turn of the 20th Century. The service essentially involved crisis counselling and interventions designed to support people through the specific crisis. In Australia today, The Salvation Army operates various programs in the area of suicide prevention and suicide postvention, furthermore we deliver a range of specific services that assist people who are at higher risk of suicide. The Salvation Army suicide prevention and postvention programs and services include:

Interventions by Salvation Army Officers and Chaplains

The Salvation Army has approximately 600 Officers {Clergy} and Chaplains. Salvation Army Officers provide a variety of support in the area of suicide prevention and postvention. Most Salvation Army Officers have been called on to provide support to families who have been bereaved by suicide. Salvation Army Officers are sometimes asked to accompany police when they visit the family to notify them of the suicide death, or to support police at the scene and Salvation Army Officers are often asked to conduct funerals for people who have died by suicide. In the past 5 years, this would have ranged from between 1000 – 1200 funerals. In most of these instances, the Chaplain or Officer would have an ongoing role in providing support to the bereaved family.

Salvo Care Line

Salvo Care Line is The Salvation Army 24 hour, Telephone Counselling Line, with branches in Sydney, Brisbane and Perth. The service commenced in 1983 and receives over 120,000 calls each year. Besides receiving calls regarding mental health, abuse, disabilities, homelessness etc the telephone counsellors speak daily with callers who are contemplating suicide.

Salvo Care Line counsellors report that there has been an increase in calls from people contemplating suicide in 2009. Some callers have a multitude of issues including loss of relationship, divorce, loss of employment leading to financial and housing problems.

We have also noted that the Global Financial Crisis has affected people from all ages and socio economic groups, resulting in circumstances beyond their control. For some people, they believe that their only option is to complete suicide.

Our counsellors also noticed an increase in calls following the death of Michael Jackson from people who wanted to "end it all". Although Michael Jackson did not die by suicide, the sense of loss experienced by many fans led to feelings of hopelessness and helplessness.

Third party calls have also been steadily increasing. These usually include people seeking advice on how to deal with the perceived emotional distress of a relative, friend or employee. Parents are the largest group of third party callers; they are very anxious about their children. Concerns are around their child behaving differently, a desire to better understand the warning signs of suicidal ideation and how to approach the young person.

The Salvation Army Hope for Life Programs

The Salvation Army Hope for Life received funding from the Commonwealth Department of Health and Ageing - National Suicide Prevention Strategy - Community Grants Program in December 2006, to develop a web site and specific training courses with a focus on bereavement support for people who have lost a loved one through suicide.

Suicide Prevention Web Site

The web site, www.suicideprevention.salvos.org.au is essentially the gateway to the suicide prevention and postvention initiatives and the portal to access the QPR and Living Hope Training Programs which are designed to raise the knowledge and confidence of the general public and particularly people who work in the area of human services. In addition, the web site provides generic and specific information about suicide prevention and postvention and is a means of promoting conferences and events. The web site also provides links to other relevant web sites and helpful resources. At a later stage we hope to explore using the web site for 'on line'

moderated discussion groups and support groups, which will be particularly useful for people living in rural and remote locations, or for those who are reluctant to join a support group in the first instance.

QPR Suicide Prevention First Aid Training

QPR – which stands for Question, Persuade, and Refer, is an on line training program which was developed by Dr Paul Quinnett, PhD. (clinical psychologist) and has been adapted to suit the Australian cultural context. QPR training includes -

- Myths and facts about suicide
- Some warning signs of suicide
- How to apply QPR
- How to offer hope and support

QPR is 3 simple steps that anyone can learn to help save a life from suicide. Just as people trained in CPR and the Heimlich Manoeuvre help save thousands of lives each year, people trained in QPR learn how to recognise the warning signs of a suicide crisis and how to question, persuade, and refer someone to help.

The QPR gatekeeper training is accessed through the Hope for Life web site www.suicideprevention.salvos.org.au and takes approximately one hour to complete.

Living Hope Bereavement Support Training for Caregivers

Living Hope is a comprehensive program which covers all aspects of suicide bereavement from practical matters to be attended to following the death of a loved one, the grieving process, aspects of spirituality, the influence and impact of culture on grieving, understanding emotions and a host of helpful information which aims to equip potential care givers to support individuals and families through the devastating experience of losing a loved one. The Living Hope training course is centred around a six step postvention model (S.P.I.R.I.T) which focuses on how to create a connection with people so that you can help them through the trauma, help them to understand their emotions and to grieve in their own unique way. Living Hope can be accessed either through a 'face to face' 2 day course or through 'on line' self paced delivery.

Hope Line

The Hope Line is a National 24/7 Crisis Line for people who have been bereaved by suicide. It was launched in September 2008 and telephone counsellors have received over 1500 calls on this line in the (just over) 12 months it has been operating. Many of the calls come from people who want to discuss emotional issues which they feel are too deep or too personal to share with another person. One woman caller commented "this is the first time in my life I have been able to share at such a deep emotional level."

Conferences

The Salvation Army Hope for Life in partnership with the Department of Health and Ageing and several key agencies working in the area of suicide prevention and postvention has hosted 2 significant National Postvention Conferences, in 2007 and

2009 respectively. The Conferences brought together survivors, caregivers, emergency service personnel, clergy, researchers, mental health professionals, youth and welfare workers to participate in the conference and hear from National and International experts in the field of suicidology. The Postvention Conferences also provided an opportunity for families and friends to participate in a Remembrance and Healing Ceremony.

Life Keeper Memory Quilt Initiative

The Life Keeper Memory Quilt was designed as a memorial to people who have died by suicide. The Life keeper Memory Quilts serve as a creative outlet for survivors' grief as well as a touching, visual reminder of so many who were lost to suicide.

By putting a 'face' on suicide, these quilts help carry the message that preventing suicide is not just about lowering statistics, but also about saving the lives of mothers, fathers, brothers, and sisters across the nation.

'The quilt is a wonderful idea and will hopefully be good for raising awareness about suicide and prevention.'

The Quilt contains the images of 62 people and was launched at a special ceremony in Sydney in August 2009, attended by family and friends of those commemorated on the Quilt. As well as being a meaningful memorial, the Quilt provided the opportunity to raise awareness of suicide. Throughout the development of the Life Keeper Quilt and post the launch event, The Salvation Army Hope for Life has made strong connections with the families involved, many of them shared tributes and stories about their loved ones and these are included in the attached Life Keeper Memories Booklet and also can be viewed on the Salvation Army Hope for Life web site.

'The quilt has brought me some comfort, knowing that our child's memory will live on.'

'I am very grateful that this Quilt Project was run. I lost my beloved son in 2007 and people seem to have a "used by date" on grief. I feel that this time now is harder to deal with now then when he died. This quilt has given me the opportunity to show the world that he did exist and still exists within my heart. I thank you for this.'

Unanimously, these families were most grateful for the opportunity to remember their loved one in this way and to meet other families to share their stories. Furthermore, they saw this as an opportunity to raise community awareness about suicide.

The clear messages emanating from this initiative are that many families need an opportunity to grieve openly and share with others. Sensitive rituals are very important in the grieving process and families need to know that they are not alone and that they have the support of a concerned community.

'I will never forget what the Salvation Army has done for me and for all the bereaved families. The combination of practical help and compassion is unique and so touching. Bless you for what you do, and thank you from the bottom of my heart.'

The Salvation Army Social Programs

The Salvation Army is one of the larger providers of social programs in Australia, providing support to disadvantaged people who are socially isolated and at risk of marginalisation through poverty, homelessness, mental illness or unemployment. The range of services provided through over 900 community and social service networks operating across Australia include AOD Detox, Rehabilitation and Counselling Services, Supported Accommodation and Crisis Support for homeless people, Family Violence Services, Counselling, Problem Gambling Counselling, Youth and Family Services, Parenting Programs, Community Support Services, Emergency Relief, material aid and Financial Counselling, Employment, Education and Training Programs and Services.

In each of these programs, our staff have consistent interaction with people who have attempted suicide, those who are contemplating suicide and families who have lost a loved one through suicide. Most of our social service staff have undertaken some form of suicide prevention training and are able to recognise the warning signs and know how to support people who may be suicidal. However, they consistently comment on the lack of service options available for people with mental health issues.

Responses to the Senate Terms of Reference

The responses provided in this submission, to the Senate Terms of Reference are drawn mainly from primary sources which include the direct experience of Salvation Army social service personnel, the feedback received from Salvation Army Officers about their experiences in working with people affected by suicide and most importantly from many families who have been involved with Salvation Army Bereavement Support Programs and those who were involved in the Life Keeper Quilt Project. These families speak of their direct experience in relation to the issues raised by this Inquiry. Although we have withheld the names of all contributors out of respect, we understand that many of these families would be happy to share their stories directly with the Senate Community Affairs Committee.

Personal, social and financial costs of suicide in Australia.

We know that according to the World Health Organisation, over 1 million people die by suicide each year and that in Australia the recorded deaths by suicide estimate that between 5 and 6 Australian dies each day by suicide. The Australian Bureau of Statistics, Causes of Death Report, states that, 'suicide continues to be a major public health issue. In terms of leading causes, intentional self-harm or suicide, was ranked 15th of all deaths registered in Australia in 2007. Males accounted for over three-quarters of all suicide deaths in 2007, resulting in a ranking as the 10th leading cause of death of males. Although death by suicide is a relatively uncommon event (occurring at a rate of about 1 per 10,000 population per year), the human and economic costs are substantial.' (ABS Catalogue 3303.0. Causes of Death Australia, 2006, released on 18 March 2009).

The personal and social cost of suicide in Australia is immense. Through our work with people who have been bereaved by suicide, The Salvation Army has a keen insight into the personal and social cost. It has been estimated that at least six people are deeply affected by each death (Hawkins K. 2006). However the ripple effect of a suicide death impacts on a wide range of people who knew the person who died and includes family, friends, neighbours, fellow students or work colleagues, teachers, acquaintances from sporting groups, clubs or social networks, health and welfare professionals and thus the impact can be felt by up to 100 people or more. The following response from a Salvation Army social worker demonstrates the impact of a suicide on professionals and other service users.

> A client in one of our residential programs overdosed on three separate occasions over a period of about two months. Staff performed CPR each time. The last time the client could not be revived. Feedback from other residents was that he had said that he no longer wanted to live. A newly graduated social worker was deeply upset by the incident. More experienced staff managed the sadness within a broader experiential context. Notwithstanding this, all were severely affected. The person's family was contacted by the chaplain who conducted the funeral service which was attended by other residents and staff. The key message conveyed was to look out for each other, both practically (amongst injecting drug users) and more broadly to show that we care and assist when people need assistance.

This submission does not attempt to estimate the financial costs of suicide in Australia, however feedback from one family member who lost a loved one by suicide states, 'we can't measure the costs, which include the affects on mental health of parents, siblings, relations, marriage break downs – divorce proceedings, family law courts, on-going counselling. No-one tracks the families of suicide victims so we will never know the real costs.'

Some families commented on the range of expenses following the death of their loved one and the financial stress adds to the overwhelming burden these families are already experiencing. One mother spoke about the general costs and also the legal costs she encountered following the death of her son.

> The financial cost I found to be a great burden. My son died with no Will which meant extra burden on finances. I had to find the money for the funeral, travel expenses, rent for his home until I could clean it out and all the other expenses that come to mind including solicitors. There is no help available for this either.
> **Name Withheld**

All of the families we work with, articulate the debilitating personal cost of losing a loved one by suicide. The ongoing trauma and stress experienced by mothers, fathers,

siblings, partners and children cannot be overstated and sensitive support needs to be available to help them to deal with their grief and trauma. One family member commented,

> 'Although we are all 'doing well', the personal cost is huge. I am sure our emotional journey is much the same as everyone else's so I won't repeat here what the journey is like. My concern is for the future well being of his two children who were 3 years and 18 months when he died. The older boy struggles now with the loss of his dad but we all anticipate the devastation they will feel when they are old enough to understand what happened. This is the cost we are most concerned about - the inter-generational cost and the fact that they are at a higher risk of suiciding. It would be helpful to provide for automatic support and ongoing monitoring of how children and immediate families are coping after a loved ones' suicide - in the same way that there is now for post-natal depression, a related topic.'
> **Name Withheld**

Furthermore research tells us that people who lose a loved one by suicide have a 9 times greater risk of suicide, (Seguin et al., 1994; Ness and Pfeffer, 1990). A Salvation Army Officer reports, 'I am aware of a local family who has had 3 male members suicide over the past 2 years. This has had a huge impact on the family and on the small local farming community where they lived.'

The following story from a woman whose husband died by suicide demonstrates that the anguish and pain is evident for many years after a loved one dies and the impact on the emotional health and well being of friends and family is severe.

> It is nearly two years since I lost my husband to suicide. I have just been discharged from hospital after a three month stay. Since his loss I have suffered almost unbearable pain, depression and anxiety. This in turn has placed me under great financial strain, placed family and friends in a now stressful situation as I fight this terrible complicated grief. My inability to participate in and undertake general day to day chores has disabled me. I suffer being suicidal myself at times. As a person who wanted to live forever, to do so much, someone who was a most successful business woman, someone now who could become yet another statistic to this means of death, as a relief from the suffering that the suicide of my husband has brought. Having now travelled down this terrible rugged road myself, may I say I personally feel we have progressed little in the past 50 years. Suicide whilst perhaps not acknowledged generally by those not personally affected, has a whirlpool effect on society in all ways, and sadly Australia is up there with one of the highest rates in the world.
> **Name Withheld**

The Critical Importance of Postvention Support

The Salvation Army has been proactively involved in working with families who have lost loved ones by suicide and we firmly believe that more needs to be done in the area of bereavement support, recognising that 'suicide postvention' is in fact 'suicide prevention'.

The mother of three children who all died by suicide, speaks passionately of the need for intensive support for siblings. Her youngest son, was just 18 years when his older brother died by suicide in 1993. There was no help available at that time for people who had been bereaved by suicide. This young man struggled deeply with the question, WHY? And his mother speaks of how she watched 'her youngest son slowly destroy his own life, until finally in so much pain he also suicided leaving behind a young son.' Her only daughter died just 3 years later.

We understand that 'the stigma that surrounds a suicide or suicide attempt often causes survivors to avoid talking about their experience, which can result in profound isolation, as well as a unique grief that can include guilt, anger, shame or embarrassment.' (SPAN 2006)

There is a need to work towards reducing the myths that lead to judgement and stigma about suicide. Many families who have been bereaved by suicide share their stories in an endeavour to raise community awareness about suicide and particularly to demonstrate that suicide has no barriers, their are no socio economic, age or racial boundaries and that whilst we talk about the warning signs, sometimes these are not apparent, individuals can hide their thoughts and plans. One mum whose three children died by suicide told us:

> I now believe with me telling my story it has started to really help others. Whilst sitting there yesterday a lady who was seated behind me drew my attention and could not thank me enough. She had read my story in the Women's Day last year after the Hope for Life Launch and because of what I said about there being no help for my kids she went and got help for her teenage daughters after losing their brother. I know in my heart or have at least until now have hoped that by telling my story and getting my books out there, it will help save lives and I guess I really do know now that I am helping others.

Conversely there are other families who feel overwhelmed by the stigma and the sense that they will be judged, which still exists around the issue of suicide and they prefer not to talk about the way their loved one died. Some families even suggest that their loved one died from a specific illness, so strong, is the sense of stigma that surrounds suicide.

These factors compound to imply that suicide death is different to other deaths. Jeffrey Jackson writing in the Handbook for Survivors of Suicide states, 'On top of all the grief that people experience after a "conventional" death, you must walk a gauntlet of guilt, confusion and emotional turmoil that is in many ways unique to survivors of suicide.' (Jackson, J 2003).

People who lose a loved one by suicide experience a deep anguish and pain. The research literature confirms that families bereaved by suicide grieve differently and that they need different types of support and understanding, than people who have been bereaved in other ways. (Clark & Goldney 1995; Clark & Goldney 2000; Dunn & Morrish-Vidners 1987; McNeil, Hatcher & Reubin 1988; Ness & Pfeffer 1990; Séguin, Lesage & Kiely, M.C.1995a).

Iris Bolton who lost her son by suicide describes the myriad of emotions that people experience including, guilt, anger, resentment, relief, abandonment, isolation, shock, disbelief and denial. (Bolton, I 2006).

The families that we have spoken to attest to the reality of these emotions, specifically

Loneliness and feelings of isolation

'My son died in France, so for the most part my comments wouldn't seem appropriate to the Australian context. I had no contact with police, coroners etc. and the funeral was held in the UK. I can only comment on the initially lonely personal experience of suicide, having been in Australia for just one month when faced with this tragedy.

I was extremely fortunate to have been referred immediately by a duty psychiatrist to Support after Suicide, a Jesuit social services organisation with trained counsellors. Without the level of support I received I would never have coped as well as I did. The Melbourne postvention conference, the quilt unveiling ceremony and all your help, have been the further crucial elements which built up my resilience. If I were to say just one thing to the Senate Inquiry it would be to urge funding to enable such programs to continue and to be expanded, as there is no doubt they can help to heal wounds which no medication could ever touch. I am still doubtful about suicide prevention as such, maybe because so many stories I have heard from other parents make it clear that our children hid everything from us, making their deaths inevitable. But I do know that after the event there is a lot that can be done to make sure the bereaved do not also plan to take their own lives.'
Name withheld

Self Blame and constantly asking 'what if '

> Thinking about the actual impact of my daughter dying by suicide rather than another type of sudden death e.g. car accident. I can only imagine, but I do imagine there would be less self-blame and all the continual questioning about maybe it was because of her childhood, what if I had done this, what if I had had the information from the QPR course and had helped my daughter open up and talk about her plans for suicide, what if, what if, what if .....this is a huge debilitating type of grief.
> **Name Withheld**

A sense of relief

> A Salvation Army Officer who provided support to a family bereaved by suicide, commented – "The family was relieved that the anguish for their brother was over as he had been tormented for years with depression. Whilst they miss him they were not sad about the action he chose."

Rage and Anger

> Response from a Salvation Army Officer
> I worked with a lady who had one son take his life and one son fail in an attempt. She only had two sons, her grief turned to rage and anger. This was directed at all her friends & family. She found comfort in a Support Group. The Support Group has loved her through all her pain and has understood her deep rage, they are patient and genuinely caring, helping her to rebuild her life & support her remaining son. This is by no means a short process, but it has kept her alive and with people who care.

The National Suicide Prevention Strategy – Community Grants Program provided funding for a number of organisations to develop bereavement support programs, to reach out to those within the community who have experienced a suicide bereavement. These types of services are essential, not only in the early stages of bereavement but ongoing. For many families, the debilitating impact of suicide can impact for years following the death of a loved one and it is critical that there are resources within the community to support families.

As stated by this family member, the loss of a loved one by suicide is traumatic and devastating and the support offered through Bereavement Support Services are greatly needed and appreciated.

> I want to thank all involved in your Bereavement Support Services to date for your continuing support and interest for those of us who are left to survive such a traumatic devastating action by a loved one. There are no words that can describe the devastation of the loss and I hope that this Inquiry will bring about further government assistance to the organisations that understand the impact of such a loss. The mental, physical, emotional and financial stress is a burden of grief in itself, affecting further the already complicated grief one is left to bear, together with the feelings of guilt that one should have done more. Whilst some lives are lost due to an impulsive act, many families are already ill, depressed and emotionally and physically drained from providing the support of their loved ones needs in treating their illness and disorder. Suicide is the final blow and those left to mourn such a loss rarely recover from such a tragedy. It goes on to affect generations.
> **Name Withheld**

There is a need to provide practical information to families after the loss of a loved one by suicide. Families are experiencing deep shock and often have no knowledge of the Coronial System and legal issues following a death, particularly when it is the death of your child and is totally unexpected. One mother advised us of the pain and embarrassment she felt as she tried to navigate the various systems following the death of her son.

> The only assistance I was offered by any of the agencies was a brochure from the Coroners Office and a follow up phone call to ask me what I thought of their service. As my son died without a Will I was unsure what to do so I rang and spoke with the Public Trustees Office to get some advice and they made me feel that I was only after his money and if he had no assets then I should just wait for a Death Certificate and see the bank. She would not listen to the questions I was asking – which was essentially, what am I supposed to do. She made me feel like a vulture, only after his money.
>
> An information book on what to do and how to do it would be great. Information about legal obligations, Wills, what to do when there isn't one, how to go about arranging the funeral, as at the time you are lost and just can't think of these things in such a short period of time.
>
> **Name Withheld**

Accuracy of suicide reporting in Australia.

It is commonly accepted within the suicide prevention sector that death rates are much higher that the recorded data released by the ABS. An often quoted anecdote is the issue of 'single vehicle accidents on straight country roads', which may in fact not be accidental deaths.

We have no evidence to provide in response to this question, however if the figures are under reported, one of the most obvious consequences of under-reporting, is that the extent of families impacted by suicide is seriously underestimated and therefore postvention support for families is under resourced. Furthermore the true financial costs of suicide are not taken into account in determining how to address this serious social issue.

Role and effectiveness of agencies - police, emergency departments, law enforcement and general health services in assisting people at risk of suicide.

Salvation Army employees and Officers have first hand experience in dealing with the various agencies who form part of the First Response team in the event of a suicide attempt or suicide completion. Common themes came through from workers and family members who had experience with police, emergency departments, general health services and mental health services. A family member commenting on her experience with the various emergency service systems, states:

> More government campaigns are needed for public awareness and acceptance, youth awareness in schools and more awareness by those dealing with the mentally ill and identifying those presenting as a risk of suicide, such as police emergency departments and general health services. I travelled the dark road with my husband for many years and felt humiliation and absolute frustration at times because of lack of support and understanding shown by those employed in health professions, doctors, nurses etc. No doubt there is now more advertising and articles on suicide and mental health issues but we need to see a greater acceptance and a sense of its 'OK to not be OK.' If it saves one life then it has been effective. I read an article recently that stated "a life lost to suicide is a loss to the world".
>
> Whilst programs, conferences, support groups etc are readily attended by those personally affected by bereavement or those worried that their loved one may be the next statistic, there is a great need to encourage police, ambulance staff, teachers, the clergy, government ministers, hospital and medical staff including both GPs and Specialists to attend. The lack of awareness generally within these groups is frightening. Our own Snr Consulting Psychiatrist was and continues to be unaware of such groups etc. On a recent visit to a Mental Health ward in a major hospital, a response from a head nurse when I wanted to discuss the increasing number of suicides and lack of understanding by those involved with the mentally ill was that "they didn't care, their only concern was that of their own family s welfare". Often there are a number of attempts prior to a suicide completion, yet these are often dismissed as an attention seeking act.

Police

Many families who have been bereaved by suicide comment on the exceptional role played by Police. They comment on the compassionate support provided by Police from the time of notification through the process of examining the circumstances of the death. One mother commented, 'the police were absolutely amazing, I could not fault their response or their compassionate attention to us at the time.'

However there were also a number of families, who felt that the Police were callous and unhelpful. A police man was interviewing a mother about her son's accident, where an inappropriate choice of words left the mother of this boy feeling even more devastated. She stated, 'the first words he greeted me with were "silly Mark* eh". He could be forgiven for not knowing what to say, but his words not well chosen just the same.'
(*Mark not his real name)

Another parent reported,

> 'Following a tragedy of this proportion one expects empathy, understanding and support from all the key people who are involved in those terrible weeks and months afterwards. But in our situation this was not the case. Because we were not at home at the time our son died, there were many questions we needed to ask. The policeman, who attended and was our contact, was uncooperative. We asked him to come out to the house as we needed to have explained to us exactly what had occurred. He refused to come and visit us and insisted we go to the station. We were consumed with grief and could hardly bear to venture outside the house so we found this very hard. I implored him to see us at home as I needed him to give us some information around the site where our son had died. I never knew whether he was not experienced or equipped to deal with a trauma of this type or he simply didn't understand how it was for us. Following a succession of problems, a capable senior officer took over and we were asked to make a formal complaint about the issues that we encountered. We will always be grateful for his input. We did receive a formal apology from the police department.'
> **Name Withheld**

It is critical that First Responders provide sensitive support and follow up to people who have lost a loved by suicide. One family stated, 'there was no one who offered any sort of assistance. A police chaplain had been on the scene at the time and left his card but we did not hear from him. We would have appreciated a phone call.'

Another comment from a bereaved family, 'after speaking to other families who have lost a loved one to suicide we found there were a lot of inconsistencies in their experiences. The follow up received seemed to depend on the action of the particular policeman who attended. One person told us they had such a compassionate

policeman, he contacted them every week for months to follow, to see how they were managing.'

Analysing the feedback we received from families relating to the support provided by Police following a suicide death, it could be observed that Police in major cities appear to have the resources and training to respond appropriately and compassionately and more needs to be done to train and support Police operating in rural and regional areas.

Notwithstanding this, from a Salvation Army social service perspective, the role played by the Police in following up emergencies and crisis situations has been extremely helpful. Salvation Army social services and crisis help lines often find it necessary to call Police to deal with emergency phone calls, and particularly to respond to people who might be threatening or in the midst of a suicide attempt. It has been reported that the Police response is always immediate and they demonstrate resourcefulness in tracking down people who have called a Crisis Line to advise that they are about to end their life. If the telephone crisis counsellor is not aware of an exact location of a suicidal person, we contact the local police in the general vicinity and the police have been cooperative in going out to locate the person.

First Response Support Teams

Salvation Army Officers and Chaplains are occasionally asked by Police to accompany them when they first attend the scene where someone has taken their own life or when they visit the family to advise that a loved one has died. This not only provides moral and personal support for the Police involved in this difficult task, it also provides a third party who can provide immediate practical, emotional and spiritual support for family members, enabling the Police to undertake their formal professional role. There is a need to recognise the importance of such support and develop and fund programs to formally train and resource clergy, chaplains etc. to undertake this essential role.

We note the important and significant work being undertaken by groups such as The StandBy Response Service and Arbor in providing a 24 hour crisis response to families who have been bereaved and would support the expansion of other postvention programs which provide this type of support throughout Australia.

There is an urgent need for human contact and practical assistance to be provided immediately after a suicide death, particularly in the hours after notification, when the police are dealing with the 'crime scene'.

One family described the experience of being notified that their loved one had died by suicide. In this particular instance the family were not provided with any basic care and because they were in a state of shock, they were incapable of providing the support they would normally provide to each other.

> We gathered outside our loved one's house soon after his death - or rather we stood around on the street outside. The inside of the house was a crime scene until the police completed their assessment of the situation, whilst the police were perfectly nice and reasonable we felt unable to talk to them or ask them questions about what was happening. We waited in the street for some 3 or 4 hours. During that time no-one spoke to us or offered us a cup of tea or a chair.
>
> There had been an ambulance at the end of the street and I don't understand why they didn't stay and help us with the shock. It was cold and we didn't have coats and we needed basic human contact help and practical support. It seems a small thing to offer a coat or a cup of tea but we needed help at that point because none of us were in a state to offer the support that we would normally provide each other. We needed someone to be an intermediary with the police and help us to deal with our grief and shock. I have since heard of the wonderful work that is done in some other states and in parts of the US where there are teams that attend at this time.

Emergency Departments

We have grave concerns about the response of many Emergency Departments to people who are in immediate crisis. It would appear that many Emergency Departments are so stretched because of lack of resources and increasing demand, people in crisis do not receive the attention and support they need. One person told us, "there is no support when I get back out. I am told to go to the mental health team in my area".

Salvo Care Line (telephone crisis help line) reports many instances where people who've called to notify that they are in the process of a suicide attempt. Salvo Care Line intervenes by calling the Emergency Department and ambulance, the person is taken to hospital and is discharged shortly afterwards. Often these individual's then contact Salvo Care Line soon after declaring that they are in the midst of another suicide attempt. When asked why they were not kept in hospital they reply "the hospital did not have the beds".

We also have serious concerns about the Risk Assessment which is conducted before a person is discharged from hospital. Firstly we believe the Assessment to be inadequate, it needs to be an holistic assessment and in most instances should ideally involve a

Social Worker to explore the factors in that person's life which led them to attempt suicide. The assessment should be focussed on whole of life issues; and should include fundamental questions in relation to the social, physical and emotional support available to the individual, e. g. do they have a home to go to?

Whilst the Mental Health protocols, state that suicidal people should not be discharged from hospital without a Risk Assessment being conducted, people quickly learn how to respond to the questionnaire. One Salvo Care Line client told a telephone counsellor, "It is easy to get out of hospital. All I have to do is tell them I am alright now and I will not attempt suicide." We are aware of one client who has been to at least 10 hospitals for suicide attempts. On only a couple of occasions has the person been admitted and remain in hospital for 24 hours. Just recently a client rang to advise that although he had slit his wrists he did not stay in hospital and was sent home.

It appears that there is very little follow up for people after discharge to check on their safety. A Salvation Army Social Worker told the story of a young man who attempted suicide. 'His friends retrieved him from out side a back-packers hostel where he had tried to hang himself. They called the ambulance and he was taken to hospital and discharged the next morning to a different back packer hostel.'

There is also a perceived lack of empathy or concern for patients who are suicidal. A Salvation Army worker advised, 'a relative of mine, later diagnosed with a mental illness, took some of her friend's pills and ended up in a major city hospital. I was disgusted with the way she was treated by the triage staff. They forget that people don't suicide for no reason, even if they (the staff) may think that the reason is stupid/silly.'

There is also a perception that professionals often believe that the person who attempted suicide is attention seeking. As one Salvation Army social worker expressed it, ' I think that sometimes services think the clients are only "crying wolf" and don't always take it seriously.'

Mental Health System

Most of the feedback we received in relation to the Mental Health system was critical of the timeliness, consistency and level of support provided through the various mental health services.

One family member commented, that 'a lot depends on the psychiatrist who is appointed to assist the individual.' In her son's case, who following his diagnosis of depression, he was referred to a psychiatrist who prescribed a specific drug which seemed to increase suicidal thoughts. Whilst this young man was not happy with his treatment the system seemed to make it difficult for him to change his psychiatrist and get the help he needed. The young man subsequently took his own life.

In our experience mental health teams are stretched and do not always go out to help a person. Furthermore some mental health teams do not provide a 24 hour service. Salvation Army front line workers provided many case studies which illustrate the short comings of the Mental Health system.

> A Salvation Army housing service duty worker took a call from a disturbed client and was on the phone to the person for a lengthy period of time. The client became more and more agitated as the duty worker explained what the service could offer. The client began to shift the focus from the original housing need and started threatening suicide. The worker was able to keep the client on the phone whilst alerting another worker who was able to glean enough information from the duty worker to place a call to the CAT Team. The CAT Team initially had little interest in the case, and refused to respond. After a further twenty minutes or so, the duty worker was able to get the client to a point where they agreed to speak with a CAT worker, at which point the CAT was called again and more information was passed onto them. The CAT worker was then willing to make contact with the client, and take appropriate action to reduce the risk of suicide. In this instance, we believe the CAT worker made it more difficult for the housing worker to assist the client, and put the housing worker in a position, that without training would have been almost impossible to negotiate a way forward with the client.

There is also a sense that the suicide risk assessment conducted by the Mental Health Crisis Assessment & Treatment (CAT) Team, appears to screen out particular clients, particularly those who are known to have personality disorders. One Salvation Army front line worker advised, 'the CAT Team has been less than helpful in almost all occasions in our experience. The questions that are asked to the presenting young person tend to evoke a response that supports a conclusion that the young person is not at immediate risk and this allows the assessor to send the young person back into the community with little or no assistance. On many occasions we have witnessed young people who have left interviews with the CAT Team showing signs that they are still at risk of suicide.'

Salvation Army personnel also report numerous instances where people had completed suicide immediately following discharge from hospital.

> One of our former clients had unsuccessfully attempted suicide and was admitted to the psychiatric unit at the local hospital. On visiting him in hospital he was still clearly quite unstable but indicated he would visit us when he was discharged. Upon discharge only two days later he made his way onto a back area of our property with significant amounts of medication and alcohol. His body was found approximately two to three weeks later on our property. A note found later by the family indicated he had returned to our property to die because it was the only place where he had ever found any peace in his life.

Families are also unsure where to get help, even when they know their loved one may be suicidal. One family stated:

> We really needed better services and help in the week before our loved one died. We knew that he was quite severely depressed but there was nowhere to take him where we felt that he would get any real support.

Another family member spoke of her frustration in trying to get support for her brother who was experiencing depression.

> Back in the year 2000, for three weeks, I attempted to contact help for my depressed brother. A family breakup was the cause, all the support for her, but little for him. I am convinced that men get the raw deal at times when families breakdown and I am angry that both genders can be treated so differently. After taking him to one counsellor and a psychologist both insisting I was over-reacting. Late one Friday afternoon I rang the psychologist extremely concerned. He was not eating, couldn't sleep, didn't care about his business, constantly calling me or just turning up day or night, in tears. He would cry for hours. Nothing I did or said made any difference. The psychologist told me to stop babying him. Monday morning, 9.08, I was notified at my little girl's school that my brother had killed himself. At the time I had no qualifications, except the fact, I knew my brother, I knew how deep his pain went.

Some families commented on the financial hardship associated with the cost of health care and medications that they experienced.

> The expenses incurred in going to your family doctor and paying for medications until they find the correct anti-depressant, while holding down a job is a huge financial stress. Somehow the Government should be suppling cheaper mental health medication for all people, not just those on a health care card.

Stigma of Mental Health

Many people feel there is still a stigma associated with mental illness. One client of Salvo Care Line, who has attempted suicide many times said that "I do not want the hospital system to consider me as part of a group of young people causing trouble in my area. The mental health system lumps us all together".

The mother of a young woman experiencing depression expressed the shame her daughter felt about spending time in a private psychiatric clinic and the difficulty the family had in navigating the mental health system.

> I understand why she died by suicide ... because she had deep depression and this was the third episode, she felt shame about spending time in a private psychiatric clinic. She could see no solution to living with depression other than ending her life. What I fail to understand is why my lovely daughter had such deep depression and why I could not find help for her and why the mental health system was so difficult for me to navigate.
>
> I have thought since she died and in cases similar to hers where she would not engage with health professionals although she gave an impression she was, where she did not have the energy for life, the trust and felt herself there was a huge stigma about depression. As a family member and her carer I was the best hope she had and maybe if I had been directed to specific support for myself we could have navigated the mental health system better.
> Name Withheld

Youth Mental Health Issues

Depression, anxiety, self-harm and suicide ideation are major health issues for homeless young people. Salvation Army youth services report, that there is a lack of accessible and affordable health services that cater for young people, including general health services, dental health services and mental health services. The ability to easily access mental health services is a high priority and requires urgent attention, particularly the issue of 'after hours' crisis services for young people.

Salvation Army youth workers, report that the hospital system is confusing for young people and the process of accessing mental health services within the hospital system varies from hospital to hospital. This lack of consistency and accessibility is confusing for both youth workers and young people.

The following is a not atypical example of the unresponsiveness of the system to support a young man in desperate need.

> Joe was also dual diagnosis and needed rehabilitation services which were not available in the area. The Salvation Army youth worker, accompanied Joe to the mental health unit and spent approx four hours waiting to see someone and then after seeing someone, they were told that there was nothing the mental health unit could do as they felt that Joe had a disability not a mental health issue, despite his having been a client of the child youth mental health services for many years.
>
> The youth worker then contacted Disability Services and organised an interview for Joe. The youth worker accompanied him to this meeting and was told by Disability Services that Joe did not have a disability and they thought he was quite capable of living independently.
>
> This process was frustrating for youth worker and the young person involved could not comprehend what was happening and all he wanted to do at this stage was find alcohol or drugs. The youth worker offered the young person accommodation for the weekend and agreed to pursue the issue for him Monday.
>
> The young man decided not to accept this offer; he then spent some time on the streets before being taken and admitted to the mental health unit. We understand that his condition has now deteriorated significantly.
> In our opinion this young person was subjected to an unsafe environment for a longer period than was unnecessary due to the lack of responsiveness of the system.
> * Joe – not his real name

Often frustrating bureaucracy makes it even more difficult for young people to access appropriate care. One of our services reported the experience of a young woman who was staying in a Salvation Army youth refuge. She had a significant history of self-harm and was a client of a mental health service in a nearby region. She called them one evening in a crisis situation, however despite knowing her history and situation, the after hours care givers could not come to the refuge as it was out of their area. She was advised to meet them 100 metres up the road as this was the boundary for their particular geographic region. We are extremely concerned about the fact that this young woman could not be treated at our centre and that she was put at greater risk, simply because she did not fit within a line drawn on a map. The system should put the person first and have sufficient flexibility to respond to their urgent needs.

Salvation Army services report many occasions where they have waited for hours in public hospitals with young people who are anxious to get medical support to deal with

an immediate crisis or to access detoxification services. The lack of beds and the limited number of medical staff on duty often means that immediate support is not available. The moment for intervention passes and the young person gives up, going back to a life of sheer survival in whichever way they can, on the streets.

Salvation Army homeless youth services provided numerous case studies of situations when vulnerable young people were inappropriately discharged either from hospital or from psychiatric facilities. One homeless young woman from rural Australia, was discharged from a major capital city hospital (against our strong recommendation) after only one week in hospital, into the care of the Salvation Army youth worker, to return to the regional youth accommodation centre. During the 200 kilometre journey home, the young woman became increasingly agitated and began self harming, the worker stopped the car to attend to her needs and the young woman's self harming behaviour escalated out of control. She was intent on killing herself, running towards the highway, trying to find cutting implements etc. She presented a serious threat to herself and others. Eventually the Police were called and the young woman who was extremely distressed and clearly seriously ill was returned to hospital. This very dangerous situation could have been avoided if the young woman had remained in hospital for a longer period as initially recommended by the youth workers.

The following is another example which illustrates some of the issues that workers in crisis accommodation services are often confronted with.

A young person entered crisis accommodation and on the second night of his stay attempted suicide by cuttings his arms, wrists and throat. The client nicked his jugular vein and was lucky to have survived.

The initial emergency response by Police and Ambulance was immediate and very helpful. The young person was taken to hospital and discharged approximately 6 hours after the incident with numerous stitches. The mental health triage team deemed that the young person was not at risk of suicide and had not attempted suicide but had only self-harmed. On the following Monday we contacted the youth mental health team and arranged for the young person to be admitted to a youth mental health facility. The young person returned to the crisis accommodation refuge after two weeks hospitalisation. At a later date the young person admitted to his youth worker, that he had actually tried to suicide. Whilst we felt that this was obvious at the time based on severity of the young person's injuries, it appeared that the first response was inadequate and moved the young person out of hospital too quickly based on the assessment where the young person stated that he was not trying to suicide.

Impact of Drugs and Alcohol

The Salvation Army has a keen insight into the impact of alcohol and other drugs (AOD) as a significant risk factor in suicide. We deliver a range of AOD services across Australia and work with people who have a dual diagnosis, people with serious alcohol addictions as well as poly drug users. We know that drug and/or alcohol misuse are significant risk factors. Concerns have been raised with us by many parents about the effect that excessive use of alcohol has had on the emotional health and well being of their child and has resulted in suicidal ideation.

The Salvation Army operates Sobering Up facilities which offer a safe and supportive environment where people can overcome the effects of alcohol intoxication and/or other drug abuse. In our experience, people are more likely to express their feelings of hopelessness, suicidal ideation and/or attempt suicide, when they are intoxicated or under the influence of drugs. In these instances it is critical to support people to remain safe and link them in with appropriate services when sober. In instances where our staff are highly concerned for the welfare of the client (i.e. they are expressing suicidal ideations and have an immediate plan) we seek immediate assistance from the Police and ambulance and find their response always supportive.

The Salvation Army AOD and homelessness services work with people with suicide ideation, which stems from an underlying depression which is sometimes associated with past (childhood) trauma. The individual often uses substances in an attempt to block unwanted thoughts but at times is under the influence of these substances when they attempt to or complete suicide. Some people who have attempted suicide from drug overdoses and then been revived, often attempt suicide again. The use of opiates in drug overdose is sometimes a mask for suicide. It is often construed that the overdose is accidental to mitigate the feelings of guilt for those left behind

A parent, whose son completed suicide, relayed her experience with her son's experimentation with drugs and the response she received from various professionals who interacted with her son.

> My son started experimenting with alcohol and marijuana at the age of 14 years. He was appearing before local courts as a juvenile offender by the age of 15 years. As a juvenile offender he had many convictions and each time he offended for a new offence he was given more bail even though he was on bail for a previous offence. The justice system allowed him to escalate as an adult to an aggravated break and enter charge that he was locked up for one year of a three year sentence. If he had have been told from his first court appearance that his behaviour was totally unacceptable to society and therefore the consequences were to be totally unacceptable to him by taking away his freedom and locking him up, things may have been different. I am no academic in these matters but I saw him become more and more cocky each

time he was granted more and more bail for doing more and more serious criminal acts.

My son had a serious drug problem from an early age, progressing to heroin by the age of 15. The courts should have "intervened" from the start and made him go to a drug rehab place as a young juvenile where he could not leave. He was sent to numerous drug rehabs as an alternative to custodial sentences but he walked out or was asked to leave from all of them. In my opinion this is the wrong approach for juveniles. They need intervention to help them to stop and take stock of what they are doing to themselves. Even some adults need intervention but we don't seem to do that here.

The police have a hard job I understand that. However a policeman told me once that "we are not counsellors". I was also told by a sergeant that I should tell my son to get out of our home, his advice was to "kick him out". Another policeman told me I couldn't force him to play cricket if he didn't want to. My son was 15 at the time and in 3 teams. I was trying to keep him in sport and also trying to teach him a responsibility to his friends and team mates. Mental health workers told me that "just let him go and he'll come back". Meaning let him go off and drink and take drugs and go wild and when he's got that all out of his system he'll get sick of it and come back.

My son had a case worker at a major hospital, mental health unit. This case worker wrote him a letter a few months before he died telling him they were closing his file.

I asked her why and she said he needs to address his drug problem. I said they were intertwined. He self medicates. Most drug addicts do. They have some sort of inhibition or mental health problem that is undiagnosed or recognised and drugs help take that away. The unlucky ones become addicted and the vicious cycle begins and can last a lifetime.
Name Withheld

General Health Services

The Salvation Army is pleased to see the commitment of the Division of General Practice to the issue of suicide prevention. We understand that General Practitioners are provided with training about suicide prevention during their basic training, which includes an informative training video and training notes. It is recognised that in many situations and particularly in rural and regional Australia, the GP is the first and main point of call in suicide emergencies.

We have had feedback however to suggest that the health system can often be very slow in assisting people. It can take weeks for people to get appointments with specialised counselling services.

A Salvation Army Officer made this comment, 'The General health services do a very good job at caring for the person who has attempted suicide. My only issue here is the ongoing care of that individual who often relapses, going back into the lifestyle that influenced them in the first place. I have found the police to be responsive but a bit heavy handed in their treatment of the individual. I have also found their response to potential youth suicide to seem dismissive.'

We would recommend that there needs to be better coordination between the various health services and support services working with people who are at risk of suicide. The various professionals involved need to ensure that integrated supports are provided including the person's local doctor, mental health services, hospital social worker, families, clergy, welfare workers and/or personal support networks.

When a support system which can include the health system, social worker, family and clergy, works effectively the prospect of a positive outcome for the individual at risk is greatly increased. A Salvation Army Officer provided details of a family situation she was called into. It provides an example of the useful role the clergy can play in bringing together the various elements of the health and welfare system.

> A little 2 year old baby was found dead in her cot, her mother discovered her. The little girl was an only child but the parents had been apart for several months. I was called to the Emergency Department at the children's hospital to minister to the family. The mother said a number of times she had nothing to live for now her little girl had gone. The father of the mum came to see me the next day concerned about his daughter and her suicidal threats. We talked for a long time about the issues, the warning signs, did she have a plan, did she have the means etc. I linked the father with the hospital social worker who was working with the family. This young woman has not taken her life and is receiving appropriate counselling.

Services in Regional Areas

We have received numerous comments about the scarcity of services in rural and regional Australia. Where there are limited services, the hours of operation are either between 9.00 a.m. to 5.00 p.m. or they only operate on certain days. As many crisis situations occur outside office hours, the only support available is often many kilometres away in the larger regional centres.

A mother residing in rural NSW made the following point:

> Talking from a regional perspective there are very few services outside of Sydney for those who are bereaved or requiring counselling or intervention. One difference in the west of NSW is that people like talking to people face to face and not just by phone so they tend not ring help lines. The wait and the cost of going to counselling is also very prohibitive.

Effectiveness of public awareness programs & their relative success in providing information, encouraging help-seeking & enhancing public discussion of suicide.

General Awareness of Suicide

The Salvation Army recently commissioned the Roy Morgan organisation to undertake a survey on our behalf to examine the level of community awareness about suicide in Australia and to try to gauge the knowledge levels of how to help a person who may be contemplating suicide.

The survey revealed that awareness of the number of people who are recorded as dying by suicide each year in Australia was low – 34% of Australians had no idea of the number of people recorded as dying by suicide in Australia each year. Only 14% of those surveyed where aware of the approximate number of recorded suicides each year.

Whilst the majority (80%) of the survey respondents were not aware of the level of suicide in Australia, over 64% of respondents stated that they had known someone who had died by suicide. While there were no statistical differences between the different age groups, there was a slight trend that more Australians have had personal experiences of suicide as they get older (52% of 14 – 17 year olds, 57% of 18 – 24 year olds, 64% of 25-34 year olds, 69% of 35 – 49 year olds and 64% of people aged 50 and older have had personal experiences of suicide).

Significantly fewer Australians from Australia's main cities (Sydney, Melbourne, Brisbane, Adelaide, Perth, Hobart) have had personal experiences of suicide compared to Australians who live outside these cities (60% of Australians from the main cities have had personal experiences of suicide compared to 70% of Australians outside these cities).

This data corresponds with the anecdotal information that The Salvation Army receives from our rural chaplains who report an increase in rural depression brought about by the drought and associated financial concerns. They work with many families and particularly men who experience a sense of helplessness and hopelessness which leads them to suicide ideation.

The survey also reports that, significantly more Australians from Queensland and significantly fewer Australians from NSW have had any personal experiences of suicide compared to all Australians (77% of Australians from Queensland have had personal experiences of suicide compared to 58% of Australians from New South Wales and 64% of all Australians).

Respondents were also asked an unaided question, (i.e. no response options were read out), regarding their awareness of support services and organisations in the community that provide support for people who are suicidal and respondents could provide multiple answers to this question. Twenty-four percent (24%) of Australians did not know any services or organisations in the community that provide support for people who are suicidal.

The results of the survey confirm our belief that there is still a sense of ignorance about the full extent of suicide in Australia. We know that more people die by suicide in a single year than through road trauma and yet the awareness levels of the issues surrounding these two social issues in Australia is vastly different. We are constantly reminded through public awareness campaigns about the extent of the road toll and how we can remain safe on our roads and yet the issue of suicide remains shrouded in mystery and seems to be seen as an individual issue and not fully recognised as the public health issue that it is.

There is also very poor awareness of the needs and experiences of families who have been bereaved by suicide. The following comment from a mother who lost her son by suicide illustrates the pain and frustration she has experience because of a lack of knowledge of the issues.

> Public awareness is quite poor I think - people just avoid you rather than talk. I have noticed that people have a "use by date" on grief. They are very supportive for the first few weeks/months and then they expect everything to be back to normal. And if I hear someone tell me that it will get easier with time once more I think I will scream. Both my daughter and I are finding it harder now as there is no support or understanding like before when it happened. That is why the quilt was so important to us.
> **Name Withheld**

The Need to understand Risk and Protective Factors

There is a need for greater public awareness around the risk and protective factors for suicide and particular for those human service agencies who work closely with people who exhibit risk factors.

The list below outlines some of the known risk and protective factors associated with suicide (Barry & Jenkins 2006; Commonwealth of Australia, 2006; Rickwood, 2005).

Risk factors for suicide	*Protective factors for suicide*
Individual • gender (male) • mental illness or disorder • chronic pain or illness • immobility • alcohol and other drug problems • low self-esteem • little sense of control over life circumstances • lack of meaning and purpose in life • poor coping skills • hopelessness • guilt and shame	**Individual** • gender (female) • mental health and wellbeing • good physical health • physical ability to move about freely • no alcohol or other drug problems • positive sense of self • sense of control over life's circumstances • sense of meaning and purpose in life • good coping skills • positive outlook and attitude to life • absence of guilt and shame
Social • abuse and violence • family dispute, conflict and dysfunction • separation and loss • peer rejection • social isolation • imprisonment • poor communication skills • family history of suicide or mental illness	Social • physical and emotional security • family harmony • supportive and caring parents/family • supportive social relationships • sense of social connection • sense of self-determination • good communication skills • no family history of suicide or mental illness
Contextual • neighbourhood violence and crime • poverty • unemployment, economic insecurity • homelessness • school failure • social or cultural discrimination • exposure to environmental stressors • lack of support services	**Contextual** • safe and secure living environment • financial security • employment • safe and affordable housing • positive educational experience • fair and tolerant community • little exposure to environmental stressors • access to support services

Salvation Army youth services work with young people who engage in serious self harming, suicidal ideation and /or attempted suicide. The issues are many and varied, it would be fair to say however that the key presenting issues for many young people include;

- Severe diagnosed and un-diagnosed depression and/or other mental health issues.
- Disconnected from their community and family
- Engaged in unhealthy peer relationships
- Drug and alcohol issues
- Lack of hope for the future

One Salvation Army worker stated, 'With regard to the families of these young people, there seems to be significant physical and emotional disconnection which no doubt has an impact on the above risk factors being present.'

Building Capacity and Coping Skills for people who have attempted suicide

There is a need to provide extensive follow up support to people who are at risk or who have attempted suicide and to help them to develop personal resilience. Often people presenting with suicidal ideations or who have attempted suicide, express a feeling of hopelessness and being overwhelmed by their issues. Their issues are often multiple and complex and can include alcohol and or other drug dependence, homelessness, social isolation, financial complexities and mental health issues. The issues rarely stand in isolation and it appears to be an accumulation of events that leads them to suicidal ideation or attempts.

Vulnerable Groups

Homeless People - Homelessness and community services need to be resourced to provide programs and counselling with will help people to develop coping skills and personal resilience. Where this is provided lives can be turned around, as shown below:

> A young man presented some time ago very close to suicide and over the past 2 years has gone from living in his car alone feeling worthless, to now having his own place and actually has his child in his custody. It has taken over 2 years but he has got there with support and competency based social programs, with one on one support.

Indigenous Australians – We recognise the devastating impact of suicide in Indigenous communities throughout Australia and the need to work with Indigenous communities to develop strategies which build the capacity of local communities to focus on solutions which address the issue of the high rate of suicide, particularly amongst young men.

Rural Australians – The rural crisis and increases in rural depression demonstrates the need to develop strategies to support people at risk of suicide. The Salvation Army recently produced a DVD on rural depression and distributed this to rural households. The Salvation Army encourages the development of programs which help rural Australians to develop coping skills to deal with the issue of depression and suicidal ideation.

Many farmers and primary males are very reluctant to seek help if they are experiencing depression as illustrated in the following story provided by a Salvation Army rural Chaplain

> We received a call from a government department asking us to meet with a farmer who was going through a tough time, he was in mediation with the banks over his property and had his header repossessed just before harvest time. He had 4 young daughters and his elderly mother to care for. He could not access help for his spiralling depression and was too ashamed to talk to his Doctor saying he was "OK". We intercepted the family at breaking point and were able to offer emotional and physical help which proved to be sufficient to prevent him from harming himself. Since this time the farmer has been able to talk with other farmers in similar situations and although not being able to access other services he 'seems' to now realise that there is hope.

Elderly People - Increasingly, we are seeing the need to target resilience programs and suicide prevention programs for elderly people. We know that people over the age of 75 years die by suicide. A Salvation Army Officer working in an Aged Care facility shared the following:

> I didn't ever think it could happen in age care but it can when a lady from our centre said that she was going out with her friend for lunch but she didn't return'.

People who are Isolated and Disconnected

The experience of feeling excluded, isolated and alone can be a powerful influence for people contemplating suicide.

The following is an excerpt from a newspaper article written about one of the parents whose son was featured on the Hope for Life, 'Life Keeper Memory Quilt'.

Article which featured in the Melbourne Weekly magazine - provided by Ms. Laura Tomei.

Building Hope – A new gym program tackles emotionally challenged youth. By Joanne Sim

Laura Tomei should have been celebrating her son's 21st birthday last month, but it wasn't to be. Her only child, Alex, took his life two years ago. The Glen Iris artist describes her beloved son as cheeky, beautiful and overly sensitive. "I believe people who suicide are born without the protective shell that most people have," she says. "There are hurdles in life and most people get over them. But some people take things too personally. They perceive things differently and Alex was one of those."

Tomei is the first to admit she doesn't have the answers, but believes it was rejection from his birth father when he was 13, which started Alex on "the roller coaster downhill". At the time of his death, Alex had left school and had recently broken up with his girlfriend. " He told a lot of people just before he died that he felt he had screwed up his whole life. I said, 'Alex, you are just 18. But he didn't realise. "Tomei explains one of the few things in life that provided Alex with huge respite and happiness was the gym. An avid body builder since he was 14, Alex regularly attended Body World in Camberwell, where he felt accepted. He trained hard and obtained certificates three, four and master trainer from the Australian Institute of Fitness – which Ms. Tomei received in the post after his death. "He built his muscles up, he loved it there and they loved him," she says. "It's just incredible how much this 18-year-old boy actually achieved. He had troubles, but also such beauty and loyalty and did it with so much heart.

"Determined to give meaning to her son's life and help other teenagers who might be struggling as Alex did, Tomei has created a support program, called Vent. In collaboration with Boroondara Youth Services and YMCA at Boroondara, the program is for financially disadvantaged and emotionally challenged young males aged from 14 to 18-years-old who are interested in weight training. The aim of the program is to help young men who are experiencing social or emotional difficulties, to attain a better outlook on life, in a friendly, non judgemental environment. "I don't want the kids involved in Vent to feel different, because that is what Alex hated," Tomei says. "There might be other kids who already go there who may already have some problems. The only thing is that they get to do it for free if they qualify for the Vent program." I have a vision. I would love kids to be able to have a place to go where there are no drugs or alcohol allowed, just creativity of some sort. In the meantime let them create their own bodies; they are in charge of their own bodies." Developing the program has helped Ms. Tomei to deal with her grief, as has writing about her feelings in journals and letters to Alex. She hopes to raise awareness in the community of the emotional struggles that can afflict our youth. "We don't talk about adolescent or suicide in general, and it's happening around us a lot. "I want people to know and the kids (who lose their friends) want people to know too. Otherwise it's almost like you are sweeping it under the carpet and its not important.

Efficacy of suicide prevention training and support for front-line health & community workers providing services to people at risk.

There is no doubt that suicide prevention training raises the confidence of front health and community workers in intervening to support people who are at risk of suicide. It is imperative that all workers in community services are able to understand and recognise warning signs and know how to take action to get people the assistance they need. As stated in other parts of this submission, more needs to be done to resource the mental health system to provide the ongoing and follow up support that people need.

The following case studies illustrate how knowledge gained from suicide awareness training can positively impact on potentially dangerous situations. (Some of these case studies refer to QPR [Question, Persuade, Refer] – which is the suicide awareness gatekeeper program, provided through The Salvation Army Hope for Life)

> A man came into my office about June this year and wanted me to go out and talk to his partner because she would not come into the church to get some help. When I went outside I encouraged her to come inside. The first thing she said as we walk into the church was "I've had enough I am going to kill myself after I leave here". I spoke to her on how she was feeling and knew that she needed to speak to someone with different professional skills to myself. I asked her permission to contact our counsellor who could come and talk with her and she agreed. While she was talking with the counsellor, I prepared a meal for her and her partner, then sat down and worked out a budget with the help of her partner for them both. I felt that both our counsellor and myself were able to turn the situation around by working together. We have both completed the online QPR which was a great help in dealing with this situation.

Salvation Army chaplains work extensively in the courts and prison system and are often confronted with people who are contemplating suicide.

> Our chaplains have been there to offer support to those bereaved by suicide including other prisoners, families, prison staff. Chaplains have completed QPR and have found this very helpful. I know that I have used it to ask the question of a person that I had been dealing with on an ongoing basis at the court where I was working at the time. I had some concern for his well-being and asked the question and he responded that he had been thinking of it. We were able to get professional help for him straight away and continued to support him from then on. Suicide is an issue that arises in the lives of those connected with the justice system.

Workers in a range of community services may be called upon to respond in crisis and having the knowledge and skills may help them to save a life. This comment came from a Salvation Army worker, working in community service setting.

> I was dealing with a client just the other day, who said to me "I don't want to live any more, it's all too much, my family would be better off without me". Because of the SA suicide online training QPR which I have undertaken I was able to easily identify this was a trigger for potential suicide, and was able to refer this client to suitable counselling.

Salvation Army workers in a social service program made the following comments;

> I received a call from an ongoing client of mine who told me about her intention to self harm. Due to training that I had received I was able to establish and disable her plan and follow up with me with promises to contact her doctor the same day (which she did). She did not follow through with her intention and is now under care of medical professionals.

> Whilst we are not a suicide prevention or suicide bereavement service, suicide is indeed something that we deal with. It is important for all of the staff at this place to be aware of the lethality indicators well before an attempt is likely, and I believe that we do this well. Staff are well trained, and many in house opportunities are given for people to improve and increase their effectiveness when dealing with suicidal ideation.

Whilst there are a variety of options in suicide prevention training, e.g. comprehensive face to face training courses, on line courses and gatekeeper courses and these are being taken up by people working in the health and welfare sector, there is still a need to actively promote these courses throughout the community and encourage workers in all business sectors to undertake this training. There is also a need to ensure that parents are encouraged to undertake suicide awareness training so that they can better understand how to approach these issues with their 'teenage' children in particular.

> In July I did a one-day suicide awareness workshop through a local community centre and found it invaluable. It was confronting and intense but I learnt a lot about how potentially suicidal people view things (themselves/everyday life). If more people had access to a course such as this I feel some suicides may be prevented.
> **Parent – Name Withheld**

Role of targeted programs and services that address the particular circumstances of high-risk groups.

The Salvation Army strongly supports the funding and resources of targeted programs and services to support people at risk of suicide, but it needs to be recognised that suicide prevention is an issue which needs to be understood by the whole community and we need to be more proactive in ensuring that all members of the community are encouraged to undertake at least basic gate keeper training in suicide awareness.

Bereavement Support Services

The Salvation Army Hope for Life program has an intentional focus on providing training to care givers in the area of bereavement support for people who lose a loved one by suicide. As stated in other sections of this submission, the deep sense of anguish and loss and the myriad of emotions that people experience, the constant questioning Why? and What if? makes suicide grief different from other grief. It is critical that people in this situation are provided with practical support and opportunities to share their grief. Training provided to community organisations, members of the clergy, teachers, health and welfare professionals will raise awareness of the grief journey and enable community volunteers and professionals to provide appropriate support to individuals and families. The Salvation Army and several other church groups also provide opportunities for families and friends to celebrate the life of their loved one through Healing and Remembrance ceremonies.

Telephone Counselling Lines

24 Hour Telephone Counselling Lines are an essential part of the support network need to provide immediate crisis responses to people at risk of suicide. In our experience, a high percentage of callers include people who have previously attempted suicide. In the majority of calls the counsellor is able to diffuse the situation and contract with the caller not to proceed with suicide. One person had a noose around their neck saying goodbye to the counsellor on a mobile. The counsellor encouraged the caller to step down out of the noose and was able to prevent the suicide death.

Salvo Care Line experienced about 80 instances in this year, where callers were in the process of taking tablets, shooting or gassing themselves. On these occasions an emergency service was called to the person and in many incidents lives were saved.

Suicide Prevention Awareness Programs

Suicide prevention training programs perform an important function in raising awareness about suicide within the community and must continue to be adequately funded and actively promoted. Many of the people who have lost loved ones by suicide, tell us, if only they had understood more about the myths and facts of suicide or had

known how to recognise the warning signs, they may have been able to intervene more directly to support their loved one. The following was written by a young woman whose brother died by suicide.

> 'I went on a crusade. I wanted to learn what I could have done. I wanted to stop others killing themselves. I wanted to spare other people the pain that my family went through and still goes through. I attended a two day workshop for suicide intervention. It was absolutely brilliant. The facilitator spoke to me after and let me know in her opinion I had preformed suicide intervention for my brother. Unfortunately I didn't have all the knowledge, of what to do next. I began to raise money, so that Cranbourne Salvation Army could get the facilitator. I promoted the course, set things up, did interviews. I eventually became a trainer, so there would only be a fee for the materials making the cost as little as possible.
>
> At one of the training workshops we taught three local police personnel who were keen to have this course to be part of the training in the academy. Counsellors, police, secondary school staff, ministers, doctors, etc. should all have this training before entering the work place. (The qualified counsellor that tried to help my brother, told me after his death and after she completed the suicide prevention training, if she had just known this stuff before things may have been different and my brother may still be alive.) This was difficult for me to swallow, it felt like she didn't believe me, she didn't have the training and so didn't have the knowledge to intervene appropriately. I also feel however that if only I had known more. I am not playing the what if's, but I have had the privilege of strangers letting me into their lives, listening to their pain, to their plans of how they intend to kill themselves, some how I've helped them to change that. It was through this training and only the training.'

Specialised Community Support Services

The Salvation Army provides a range of community support programs and services to support people who are at higher risk, including

- Disadvantaged young people
- Homeless people
- People with Drug and Alcohol addictions
- Families in financial crisis
- Rural families and farming communities impacted by the drought.
- People with gambling addictions

Some of these people may be experiencing mental health issues but overwhelmingly the issue confronting most of the people we work with is a deep sense of hopelessness, helplessness and sometimes a sense of worthlessness. The role provided by community

services and church agencies throughout Australia in providing a place of safety, community connection and a place where people can rediscover their self worth. The Salvation Army social programs and community centres, whilst delivering specific social services also endeavour to provide a place of belonging for everyone. When people who are struggling with suicidal tendencies feel that they are a valued part of a community, they are given strength and hope to continue living.

Salvation Army rural chaplains provide counselling and practical support to farmers and rural families, who are experiencing financial and emotional stress. Many of these families are asset rich and income poor and have a proud history and tradition of self reliance and are often reluctant to seek external help.

Whilst many of The Salvation Army social services are not directly targeted at addressing suicide, there is no doubt that these programs do have a significant impact in this area.

Dr Frank Campbell, (Executive Director Crisis Center Foundation & the Office of Clinical Research & Consultation, past president of the American Association of Suicidology.)

"When it comes to suicide prevention there's probably no organisation that's had a larger footprint around the planet than The Salvation Army." "The Salvation Army covers such a wide array of services and they work way upstream from the place at which people choose to die. We don't know how many lives they save because of the other work they do in the area of helping the homeless and helping the needy and all the other individuals who might one day find themselves in a place of distress where suicide would be their natural response to that distress." "The Salvation Army for 100 years has taken so many people out of the river of risk - we may not know what the true rate of suicide would be today were it not for The Salvation Army."

One Salvation Army youth worker talked about a 9 year old boy, who attended a church kids camp. This young boy was exhibiting signs of social withdrawal and stress. Over the period of the camp, one of the leaders was able to build a relationship with the boy to the point that the child shared openly about the things at home that were concerning him. This child already believes that he is hopeless and "a mistake". We were able to speak a different reality into the child about his worth and possibilities. He is now linked with ongoing support with a youth worker at his local corps, and we are looking for appropriate services to refer to in his local community, should intensive counselling be required.

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.

Whilst we recognise and respect the great body of literature and we value the research that is undertaken in the field of suicide prevention and postvention, we have concerns that this information is not readily accessible to practitioners within the health and welfare sectors. We need to ensure that this valuable material is synthesised and incorporated into salient messages disseminated through mediums that will reach the front line staff who are working with people at risk of suicide. Strategies to ensure this occurs should include working in partnership with peak bodies, professional associations and the health, education and community services sector.

Effectiveness of the National Suicide Prevention Strategy

From The Salvation Army's perspective the National Suicide Prevention Strategy has realised some of its objectives. The funding of community organisations has seen the development of a range of community based suicide prevention and bereavement support initiatives, which have served to raise awareness of the issues and has endeavoured to penetrate the broader community.

However the issue of suicide is still largely seen as a mental health issue and not been taken up by the wider support system. It is critical that all personnel working in human service fields and particularly in community service organisations understand the impact of suicide and know how to support people experiencing suicidal ideation. This applies to Schools, General Health Services, Employment Agencies, Neighbourhood Houses, Community Service Agencies, Homelessness Services, Drug and Alcohol Services, Family Support Services etc.

We are also pleased to see the development and implementation of the Media Guidelines which has led to more responsible reporting of the issue of suicide. It is encouraging to note the sensitive ways in which stories relating to suicide and mental health are reported and to see the inclusion of the Telephone Help Lines and information web sites in media coverage. The adherence to the Media Guidelines by both the electronic TV media and the press and the reduction in inappropriate media coverage of suicide also prevents copy cat suicides.

Whilst most mainstream media adhere to the Guidelines for reporting suicide in the media and are aware that these are readily available through the Mind Frame web site www.mindframe-media.info/, family members raise issues of the sensationalising and sometimes glamorising of suicide that occurs in TV dramas and films etc and suggest that more needs to be done in these instances to try to convey the devastating that

occurs within families when a loved one dies by suicide. Suicide awareness raising and education of all public figures is critical.

> There has been a sea change in talking about mental health and that is great, especially the public admissions by high profile politicians and sportsmen. However there is still some difficulty in talking about suicide. I'm not sure why. Perhaps it scares people too much. Also, as with all mental health issues, people have a perception that the person's whole life must be bad. As you know, in reality many people with mental illness and those who commit suicide can be living productive, happy and 'normal' lives 90 % of the time.
>
> However, the 'publicity' that is really counter-productive in my mind is the constant use of suicide in novels, films, TV as a plot twist and is often shown as an easy way out of a difficult situation. The devastation is never displayed. I think this type of modelling of suicide as a problem solving behaviour is really damaging.

Conclusion

This submission has drawn heavily on the experience of Salvation Army Officers and employees who daily endeavour to provide support people who are struggling with the pain of hopelessness. Our suicide prevention and postvention programs are called 'Hope for Life' because we understand that hope is what people who are in pain need most. We need the support systems within the community to work collaboratively to provide wrap around supports to people in crisis.

We respectively make the following recommendations to the Senate Inquiry and would welcome the opportunity to further elaborate on the issues raised in this submission.

Recommendations

1. **Promote the value of life for everyone and raise community awareness of the resources and information provided through the Living is for Everyone (LiFE) Framework.**

2. **Develop public awareness campaigns to educate the public about myths and warning signs of people who are suicidal.**

3. **Develop specific resources to help to inform parents about the issues of suicide and how to refer their children to appropriate support.**

4. **Continue to raise awareness around the issue of mental illness to educate the public on how to support people with mental illness.**

5. **Provide additional resourcing for Bereavement Support Training, recognising that suicide postvention can also be suicide prevention.**

6. **Provide specific training and support to members of the Clergy as potential first response support teams alongside police and emergency services.**

7. **Promote web based training courses on suicide prevention of suicide, recognising the wide accessibility of the internet and the ability to reach people in remote locations and those who may be reluctant to undertake face to face training.**

8. **Resource homelessness and AOD services to develop capacity building and resilience programs to support people who are socially isolated and/or disconnected young people who have limited family or personal support networks.**

9. **Develop suicide prevention and support programs which focus on provision of support to elderly people.**

10. **Develop better connections and protocols between hospital health workers and the mental health teams in providing 'wrap around supports' to people who are feeling suicidal.**

11. **Provide avenues for Mental Health Advocacy groups to recommend and implement changes in the mental health system in response to client needs.**

12. **Ensure that specialist beds are available to enable the hospitalisation of people who are feeling suicidal so the person can be observed and monitored.**

13. **Work on improving the practice standards of the Risk Assessment when people enter the Emergency Department following a suicide attempt to avoid the possibility that suicidal people might be able to anticipate the perceived correct answers which ensures an immediate discharge from hospital.**

14. **Ensure that the Suicide Risk Assessment conducted in Emergency Departments also examines the physical, emotional and social supports available to the individual. i.e. if the person is homeless or living alone, ensure that social welfare agencies or church groups are contacted and resourced to provide additional support to people on discharge.**

15. **Ensure that adequate support is provided to people who are discharged from hospital following a suicide attempt. A Hospital Discharge Case Plan should be developed that would provide intensive support following discharge that**

would progressively by withdrawn as the episode passes. The support plan could include family and friends and would mean that the individual could leave hospital and return to a more "natural" environment. Funding should be provided for 'support persons' to be available 24/7, immediately following discharge.

16. **Pilot a 'Care House' initiative to provide a supported and caring environment for people who are homeless or living alone, who are discharged from hospital following a suicide attempt.**

17. **Develop and fund early intervention programmes for teenagers and school children which focus on the value of life, peer support, self soothing and resilience.**

18. **Ensure that joint protocols are developed between mental health services and community support services.**

19. **Facilitate home visits by Mental Health Team workers for people discharged from mental health units, to assess progress and ensure that people are taking appropriate medication**

20. **Fund specific programs which focus on creative and fun activities which provide people with an opportunity to socialise especially during difficult times. Recreation and social activities play an important part in helping people through periods of mental and emotional crisis.**

21. **Implement drug and health education harm minimisation programs that encourage a young person to stay safe, until such time as they are ready to address their particular issues.**

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