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Senate Community Affairs References Committee: Inquiry into suicide in Australia.

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Thank you for this opportunity to give input into your Inquiry on the issue of suicide. Suicide remains a taboo subject to many citizens. It is often linked in the minds of the public to mental illness and the associated stigma thereof. Cultural and religious views also have an impact on how Australians perceive and react to suicide.

Terms of Reference:

[a] Suicide costs Australia dearly. It affects the young, the highly skilled and every strata of society. One can only estimate the cost of a suicide of a 15 year old, a 40 year old researcher in health, or an 80 year old artist. Alternatively, as a health care worker, on occasion doing suicide risk assessments, a person's rationale for suicide can be well thought out and reasonable. These are difficult questions of ethics.

[b] The accuracy of reporting suicide is very questionable. For example, I have done mental health assessments at casualty wards in hospitals when the nursing staff have realised that the driver deliberately drove their car into a tree. If that person died it would have never been regarded as suicide, just another car accident on a country road. There are many such examples which lead me to believe that there is much under-reporting. Stigma and the bureaucracy of dealing with suicide may also impact on under-reporting of suicides.

The mental health services are obscenely under-resourced. Consequently "priorities" are set – subjective decisions are made on where resources are spent – at risk people are not always be serviced; politically sensitive issues may get disproportionate resources. Some Bureaucrats seem to have the duty of keeping within [inadequate] budgets at all costs and minimising negative publicity.

[c] Services to people at risk of suicide are inadequate. Most health care workers, police and legal agencies didn't sign up to be mental health workers or suicide interventionists. More training and numbers of these people would help along with dramatic increases in mental health services.

To exemplify: most times when I was called to a volatile situation the first thing you do is get rid of the police, out of sight [after getting a sketch of what is going on]. I know the police usually don't want to be there, that there are unlikely to be mental health beds available and even if there were the admission would likely be inappropriately short. A good outcome is that no one gets hurt, no one gets arrested and no one gets admitted to a psychiatric institution [band aid solutions].

[d] Public awareness campaigns and community perceptions are improving. We can talk about mental health, suicide and child sexual abuse in our community quite differently than 30 years ago. Increased help-seeking behaviours need to be matched with increased resources for assisting those in need.

Early this year I did a community project in a rural town with Robert Dipierdomenico the football Star ["Dipper"]. School kids and adults went to see and hear "Dipper" but they also got a short down to earth spiel on suicide, drug abuse and mental health from me. I am sure no one remembered me but they did remember the message. Feedback suggests this worked better than expected, especially with the high school and younger people.

[e] Suicide prevention training has become more widespread such as *Mental Health First Aid*. However, there are not enough services to refer people to once a risk is identified. When I did Psychology at University there was no training at all, no practical components, no patient contact. Unfortunately you learnt on the job. Most of the vital skills I learnt from nurses in regard to doing suicide risk assessments and keeping yourself safe. There needs to be major changes in how health care professionals are trained and supported.

[f] Targeted programs seem to come and go with whoever has political influence. There seem resources for target groups at different times: the elderly, the young, the same sex attracted, for post natal depression. Then the target shifts and resources disappear just when benefits occur. Obviously the people at the front line know what works and what doesn't work in their neighbourhood – they should be directing services, not distant politically motivated bureaucrats. The example of the treatment of our indigenous population clearly illustrates this.

[g] Research is vital into suicide and the diseases that have high risk such as schizophrenia. Suicide is also a social issue influenced by the economic situation, crimes such as sexual abuse, and anomie. Therefore social research [and change] is needed. Such research needs to translate into action at the front line, no matter how politically uncomfortable this may be for some. Suicide is objectively measureable; it is hard for the spin doctors to refute.

[h] The major barriers to the National Suicide Prevention Strategy are the dearth of physical and human resources. Probably the greatest allocation of resources needs to be in primary prevention. For example, small independent local multidiscipline teams with clear simple goals and who are well resourced.

In conclusion, we can not reasonably expect to have no suicides in our community: but we can strive to minimise the number. I wish your Inquiry well and hope to see monumental increases in resources in the near future.

Yours truly,

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