School of Health
Faculty of The Professions
Armidale NSW 2351
Phone 61 2 6773 3661
Fax 61 2 6773 3666
Email: m.maple@une.edu.au

Thursday, 3 December 2009

Mr Elton Humphrey
Committee Secretary
Senate Community Affairs References Committee
PO Box 6100
Parliament House
Canberra ACT 2600
community.affairs.sen@aph.gov.au

Dear Secretary,

Thank you for the opportunity to make a submission to the Senate Inquiry into Suicide in Australia.

The following submission particularly focuses on:

Terms of Reference A
(*personal, social and financial costs of suicide in Australia*)
and
Terms of Reference G
(*current program of research*)

Should you have any queries relating to my submission please do not hesitate to contact me, as per details below.

Yours sincerely,

Dr Myfanwy Maple, PhD
School of Health
University of New England

Submission to the Senate Inquiry into Suicide in Australia

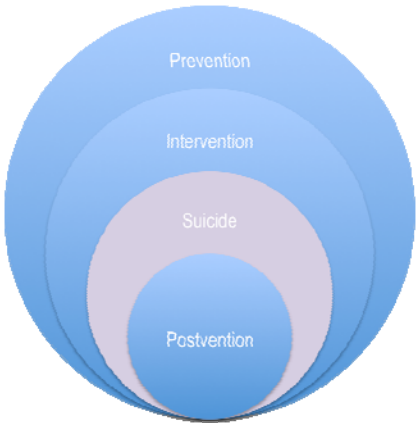
Dr Myfanwy Maple
University of New England
Armidale NSW Australia

Terms of Reference Item A:

The personal, social and financial cost of suicide in Australia

With around 2000 suicides occurring every year in Australia, and particular groups known to be at elevated risk, government commitment to better understanding suicide must be ongoing. Australian governments have done relatively well at funding and increasing the profile of suicide prevention over the last two decades when compared with like countries internationally. Yet, much more needs to be done. Importantly, to date the focus has remained on suicide prevention and intervention. There is a third neglected but equally important factor in suicide – and that is postvention, as indicated in the diagram below.

Enmeshed in Suicide: Prevention, Intervention ***and Postvention***



Postvention and those bereaved by suicide have largely been ignored. Where many government reports and research publications mention those bereaved by suicide being at increased risk of this is not integrated in any meaningful and constructive way to better understand why this might be

the case or the needs of these individuals. While prevention and intervention have primarily been in the realm of public health, postvention has been left largely to the non-government sector with no clear processes, funding lines or evaluations of the few services that have ventured into servicing this population.

When thinking about the morbidity and mortality related to traumatic deaths, the suicide-related burden cannot be underestimated, yet remains unknown. Using conservative estimates, it is thought that around six people are affected by each suicide death (Clark and Goldney 2000). This figure is viewed by most in the field as grossly inadequate with some suggesting as high as 100 people are affected each time someone takes their own life. However the true number remains elusive. At the very least we can assume at least three generations in family being bereaved through the suicide death of a loved one (Cantor, Neulinger et al. 1999), along with friends, acquaintances and colleagues. Within some groups the numbers who may experience grief following a suicide death will be much higher. These groups include young people (where peer networks are vitally important), Indigenous communities (where extended kinship systems are the norm) and in rural communities (due to the multiple relationships and connections people have). Importantly, these groups are already confirmed risk groups for suicide, with higher numbers of deaths occurring within these groups, and so are also more likely to be bereaved through suicide.

I have been researching in the area of 'bereaved by suicide' for the past decade and remain in a state of disbelief by the lack of focus on those who are left behind following the death of a loved one. I believe that given the increasing body of literature that relates to the needs of those affected by suicide (please see reference list at the end of this submission for key recent Australian research being published in this field), that there needs to be a commitment within any future Government strategy or plan that addresses these three distinct, yet enmeshed, components of suicide: **Prevention, Intervention *and* Postvention**.

Federal and state government policy contexts need to address all three areas holistically and these need to be linked within a strong policy and

evaluative basis. The logical first step of bringing postvention issues in line with the two other components of suicide is to update the NH&MRC 'Setting the Evidence-Based Agenda for Australia: A literature Review' (1999) which now a decade on misses many of the lessons learnt through the first decade of this century.

In undertaking this task, the word 'Postvention' needs to be defined. Originating in the United States, postvention refers primarily to services aimed at assisting those bereaved by suicide. However, this definition is too narrow. While service needs are an important aspect of addressing a major public health issue, focusing solely on this does not do justice to the broader social and cultural aspects of suicide. Furthermore, those who have had intimate contact with someone who has chosen to take their own life can teach us important lessons about the suicide act in and of itself, in addition to being recipients of services. ***These individual people are more than a risk group for suicide***.

Bringing this part of the suicide puzzle alongside prevention and intervention is vital in understanding this phenomenon from a well-rounded point of view. This will not occur without a concerted effort to reduce stigma related to suicide. Stigma does not only impede those ill informed about the issue. Stigma also affects the nature of the work done in the suicide arena by well-meaning researchers, academics and practitioners. Until we acknowledge that *some* suicide deaths will occur, we cannot adequately place bereavement following suicide death on the agenda. Of course, the most important work is to reduce the number of deaths and the burden associated with risk and attempts. However, we also **must** acknowledge that when someone dies in this manner there will be related bereavement and for some this will require professional help.

Terms of Reference Item G:

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

Few researchers internationally have paid attention to those bereaved by suicide. More often than not when those bereaved by suicide are mentioned in the research literature it is in comparison to those bereaved through other forms of traumatic death (for example, Murphy 1997; Murphy, Johnson et al. 1998; Jordan 2001). Rarely are those who have lost a loved one asked about their experience (Maple, Edwards et al. in press). Yet, there is a lot we can learn from them both to assist those within this group who may require additional support through postvention services, as well as helping to shed light on the phenomenon of suicide. Research in this area is constrained by a number of inter-related issues, including:

1. Suicide research is *believed* to be traumatic on both the research and the participant. However, this is not necessarily the case. With careful planning and appropriately trained researchers, it is unlikely that there will be any negative outcome on either the researcher or the participant (Maple, Edwards et al. in press).

2. Suicide research is often *blocked or amended* by ethical clearance committees due to their judgements about the impact on those who may participate, which is shaping the knowledge in this area. This is a vitally important issue. In the United States, most participants for suicide bereavement are sourced through support groups. The outcome of this is that the knowledge generated from the research is primarily from those who seek external assistance through self-help groups following the suicide death of a loved one. In Australia, there is a slightly broader sample, however support groups remain the choice of recruiting locations for ethical clearance bodies. At my own

institution, we have been limited by our ethics committee to recruiting through the media and support groups. Therefore we only speak with those who are willing to make the first step following hearing or reading about our research. Again, this is limiting the diversity of views and experiences by those bereaved by suicide. This limits the construction of knowledge in the area.

3. Suicide is *stigmatised*. No one wants to talk about suicide and suicide death. However, should one bereaved by suicide be genuinely asked to talk about their experience they are often very keen to share their story in the hope of helping others – both to help reduce the number of deaths as well as help those who find themselves bereaved in this manner.

4. Suicide bereavement research is not high on the research *funding agenda*. The focus on preventing deaths is important. The more lives saved, the fewer who will be bereaved by suicide. However, throughout history there have been suicide deaths, and in the future there will be. It is vital that suicide bereavement research is placed with similar importance on any funding agenda. In addition, because there is not a lot known about suicide bereavement most often small qualitative studies are proposed to commence scoping the research agenda. These studies are vitally important to start to build a case for large scale, quantitative research that is more likely to be funded.

5. Suicide prevention and intervention sits within the *portfolio of mental health*. Yet, suicide bereavement does not fit in this category and is therefore not easily defined within the research coding and funding opportunities. Furthermore there is a strong argument that suicide should be much broader than this also, with around a third of all suicide deaths not linked to mental health problems.

6. There is a lack of vision for a *suicide bereavement research agenda*. There are very few researchers actively working in the suicide bereavement field in Australia (see attached key Australian reference list). There are a limited number of services offered to those bereaved by suicide. A core group, including Lifeline, StandBy

Response and the Salvation Army Bereaved by Suicide services, along with the named researchers above have commenced setting a priority agenda for suicide bereavement in the absence of a national agenda. The first planned project being developed for an Australian Research Council Linkage Grant in 2010 is to commence examining the true number of people bereaved by one suicide death, identification of those who may require support services following this bereavement and the type of service required. This will provide a starting point for setting the agenda for research in this area (more information relating to this can be provided on request).

Key Priorities Identified:

- Suicide related activities must include: prevention, intervention and postvention
- Stigma must be addressed to reduce suicide and promote understanding of all areas of suicide behaviour and the outcomes of suicide
- A suicide postvention research agenda is required with clear priorities being well understood
- Funding and ethics committees need to be educated about suicide bereavement and postvention
- Suicide is not only a mental health problem – it is a whole of community issue

Key Australian references relating to suicide bereavement

Maple, M., Edwards, H., Plummer, D. & Minchiello, V. (in press) "Silenced voices: Hearing the stories of parents bereaved through the suicide death of a young adult child." Health and Social Care in the Community available online: DOI: 10.1111/j.1365-2524.2009.00886.x

Maple, M. & Edwards, H. (2009). "Locating and understanding voice in narrative inquiry: A journey of discovery." Qualitative Journeys: Student and Mentor Experiences with Research. V. Minichiello and J. Kottler. Thousand Oaks: Sage.

Maple, M., Plummer, D.; Edwards, H. & Minchiello, V. (2007). "The effects of preparedness for suicide following the death of a young adult child." Suicide and Life-Threatening Behavior **37**(2): 127-134.

Maple, M. (2005). Parental Portraits of Suicide: Narrating the loss of a young adult child. Armidale, University of New England**:** Unpublished Thesis. Available at: https://e-publications.une.edu.au/vital/access/manager/Repository/une:3248

Maple, M. (2005). "Parental bereavement and youth suicide: An assessment of the literature." Australian Social Work, 58 (2) , 179-187.

Ratnarajah, D. (2005). The construction of meaning following parental suicide. Armidale, University of New England. Unpublished Masters Thesis.

Ratnarajah, D. & Schofield, M. (2007). "Parental suicide and its aftermath: A review." Journal of Family Studies **13**(1): 78-93.

Ratnarajah, D. & Schofield, M. (2008). "Survivors' narratives of the impact of parental suicide." Suicide and Life-Threatening Behavior **38**(5): 618-630.

Sands, D. (2008) A study of Suicide Grief: Meaning making and the griever's relational world. University of Technology, Sydney. Unpublished PhD thesis. Available at: http://epress.lib.uts.edu.au/dspace/bitstream/handle/2100/777/01front.pdf?sequence=1

Sands, D. & Tennant, M. (in press) "Transformative learning in the context of suicide bereavement." Adult Education Quarterly.

References

Cantor, C., K. Neulinger, et al. (1999). The epidemiology of suicide and attempted suicide among young Australians. National Youth Suicide Prevention Strategy: Setting the Evidence-Based Research Agenda for Australia (A Literature Review). Canberra, Department of Health and Aged Care, Commonwealth of Australia: 1-112.

Clark, S. and R. Goldney (2000). The impact of suicide on relatives and friends. The International Handbook of Suicide and Attempted Suicide. K. Hawton and K. van Heeringen. Chichester, John Wiley and Sons: 467-484.

Jordan, J. (2001). "Is suicide bereavement different? A reassessment of the literature." Suicide and Life-Threatening Behavior **31**(1): 91-102.

Maple, M., H. Edwards, et al. (in press). "Silenced Voices: Hearing the stories of parents bereaved through the suicide death of a young adult child." Health and Social Care in the Community.

Murphy, S. (1997). "A bereavement intervention for parents following the sudden, violent deaths of their 12-28-year-old children: Description and application to clinical practice." Canadian Journal of Nursing Research **29**(4): 51-72.

Murphy, S., C. Johnson, et al. (1998). "Broad-spectrum group treatment for parents bereaved by the violent deaths of their 12- to 28-year-old children: A randomised control trial." Death Studies **22**(3): 209-235.