Australian Government

Department of Health and Ageing

SENATE
COMMUNITY AFFAIRS REFERENCES COMMITTEE
INQUIRY INTO
SUICIDE IN AUSTRALIA

Submission from the
Department of Health and Ageing
December 2009

TABLE OF CONTENTS

LIST OF APPENDICES

LIST OF FIGURES

LIST OF TABLES

LIST OF ABBREVIATIONS

ABS	Australian Bureau of Statistics
AIHW	Australian Institute of Health and Welfare
AISRAP	Australian Institute for Suicide Research and Prevention
ASPAC	Australian Suicide Prevention Advisory Council
ATAPS	Access to Allied Psychological Services
DOHA	Department of Health and Ageing
FAHCSIA	Department of Families, Housing, Community Services and Indigenous Affairs
ISWG	Indigenous Strategies Working Group
MBS	Medical Benefits Scheme
MHSRRA	Mental Health Services for Rural and Remote Areas Program
NCESP	National Centre for Excellence in Suicide Prevention
NCIS	National Coronial Information System
NHMRC	National Health and Medical Research Council
NSPP	National Suicide Prevention Program
NSPS	National Suicide Prevention Strategy
PBS	Pharmaceutical Benefits Scheme
WHO	World Health Organization

1. INTRODUCTION

Suicide is a complex and multidimensional issue, which has a devastating impact on individuals and families and ongoing implications for the communities in which they live. The emotional, social, health, genetic and environmental factors that result in an individual experiencing suicidal thoughts and behaviour vary enormously, and the causes and precipitating factors for every individual suicide are also likely to be different. However there are well recognised risk factors for suicide, and conversely, evidence based protective factors which reduce the likelihood of suicide for individuals and across the population.

The Australian Government has played a significant role in suicide prevention since the introduction of the National Youth Suicide Prevention Strategy (NYSPS) in 1995 and then the first National Suicide Prevention Strategy in 2000. Suicide prevention has significant health related dimensions, including the higher risk of suicide among individuals who are living with mental illness or drug and other alcohol abuse, and also those living with chronic illness or pain. In fact, the single biggest risk factor for suicide is the presence of a mental disorder – so broader mental health services and programs that aim to either prevent, intervene early or effectively treat mental disorders will therefore contribute to a reduction in self harm behaviour and suicide. As such, the Department of Health and Ageing (DOHA) leads the implementation of the Australian Government's suicide prevention policy and programs and the provision of accessible mental health treatment represents one of the largest Australian Government investments in interventions that lower the risk of suicide.

However suicide also has broader dimensions that involve everyone in the community where a person who is feeling suicidal is marginalised or isolated because of unemployment, housing instability, financial stress, disengagement from school or the community, or poor family or intimate partner relationships. Accordingly, the programs of many other Australian Government agencies, state and territory governments and community organisations enhance the work of DOHA in suicide prevention.

Key data on suicidality in Australia is discussed in Section 2. According to currently available official data and compared to other causes of death such as cardiovascular disease or cancer, from a population perspective suicide is technically a low prevalence event. This should not reduce the fact that every death by suicide is clearly a high impact event. In 2007 in the 15-24 and 25-34 year age groups, it is the highest ranking cause of death in Australia[1]. Suicide is usually preceded by a period of extreme distress for the individual, although some suicidal behaviour is impulsive in nature, particularly where substance misuse is also involved. The impulsive nature of some suicidal behaviour creates challenges for efforts to predict and prevent suicide. The lead up to, death by and aftermath of a suicide have profound and negative effects on a large number of individuals around the deceased.

The official Australian Bureau of Statistics (ABS) data on deaths by suicide suggest a significant decline in suicide over the last 10 years[1]. The ABS has acknowledged that this data source has over this time been incomplete and that there is likely to have been a higher number of suicides than has been reported. This issue is discussed in greater detail in Section 3. However there is still broad based agreement that suicide rates have been falling in Australia for the last decade.

An understanding that the rate of suicide in Australia has been declining has not led to complacency by governments or the community. In fact, the sense that interventions can change the suicidal behaviour of people has encouraged an increasing attention to suicide prevention and the Australian Government has increased its allocation on specific suicide prevention programs from $8.7m in 2005-06 to $22.2m in 2009-10 (refer to Section 4). This forms part of a broader Commonwealth investment totalling $1.9b a year on mental health services and programs.

Section 5 discusses Australia's strategic approach to suicide prevention in Australia and the four interconnected elements of the National Suicide Prevention Strategy (NSPS):

- the Living is For Everyone (LIFE) Framework, which sets an overarching evidence based strategic policy framework for suicide prevention in Australia;
- the National Suicide Prevention Strategy Action Framework, which provides a time limited workplan to guide the work of DoHA and the Australian Suicide Prevention Advisory Council;
- the National Suicide Prevention Program (NSPP), which is the Australian Government funding program dedicated to suicide prevention activities; and,
- mechanisms to promote alignment with and enhance state and territory suicide prevention activities, particularly to progress the relevant actions of related national frameworks, such as the COAG National Action Plan for Mental Health 2006-2011[6] and the Fourth National Mental Health Plan 2009-14[26].

There is also a general agreement that the number of deaths by suicide in Australia is still too high. While it may not be possible to prevent every suicide, there is a continuing need to improve efforts to further reduce suicide rates. Further, the data and evaluation evidence available suggests that not only do different population groups demonstrate different rates of suicide but different groups respond differentially to suicide prevention efforts. In response to this, over time, the Australian Government has re-examined the types of activities supported under the NSPS and its investment arm, the NSPP to improve the targeting and effectiveness of funding on activities that help people at higher risk of suicide. Sections 6 and 7 present universal, population based interventions, including research, and targeted interventions respectively. Investments in research and sector infrastructure are detailed in Section 8.

Importantly, the direction and focus of suicide prevention effort and investment in Australia has evolved over time in response to changing evidence about the nature of suicide, changing evidence as to what are the most effective interventions and changing evidence from evaluations of the program about its effectiveness. In addition to broad evaluations of the NSPS itself, the evaluation of individual projects has supported decisions about future directions and investment. Plans are underway for an evaluation of the current phase of activity to conclude in 2010-11. Further details of evaluations of the NSPS are presented in Section 9.

There are also continuing challenges in realising a better understanding of suicide and what interventions work best for particular groups at risk of suicide given the complexity of this area. However, the Australian Government has also increased its efforts in improving the evidence base and in communicating this knowledge base within the community. New evidence will continue to inform future iterations of the NSPS and the most effective points of future investment. Future challenges are outlined in Section 9.

2. SUICIDALITY IN AUSTRALIA

- *Pathways to suicidal crisis are complex and multifactorial.*
- *Suicide is a low prevalence, high impact event that is not evenly distributed across the population. Some population groups are disproportionately affected by suicide.*
- *Most recent official ABS data indicates that 1,881 deaths were officially registered as suicide in Australia in 2007. This is a reduction in the number of deaths officially registered as suicide from 2,722 in 1997.*
- *While there are recognised distortions in the data, it is generally acknowledged that the rate of suicide in Australia has fallen over the last ten years.*
- *The reduction has not been even across all groups and some groups may not have experienced a reduction at all.*
- *There are still too many deaths by suicide in Australia.*

A death is classified as a suicide by a coroner based on evidence that the person died as a result of a deliberate act to cause his or her own death. A suicide should therefore be distinguished from unintentional self harm that may or may not be fatal. It should also be distinguished from deliberate self harm without the intent of fatality, which may nevertheless result in fatal injury. A number of non-fatal behaviours are closely related to suicide: non-fatal suicidal actions, suicidal ideation, and planning suicide. Taken together with suicide itself, this group of behaviours can be described as suicidal behaviour or suicidality.

Resilience and vulnerability

Everyone experiences stress and difficult circumstances during their life. Most people are able to cope with most of the difficulties and stresses they encounter but others may be vulnerable and react very negatively, even contemplating suicide, in response to stressful life events. The way a person copes with difficult circumstances is a complex matter, but one that can be described broadly in terms of the protective factors that contribute to their resilience and the risk factors that contribute to their vulnerability.

Suicide prevention most generally consists of efforts to enhance a person's resilience and reduce their vulnerability so they are less likely to feel suicidal when faced with major stress or difficulty. Figure 1 identifies some common protective and risk factors that may influence a person's suicidality in times of crisis.

Figure 1: examples of Protective and Risk factors for Suicidality

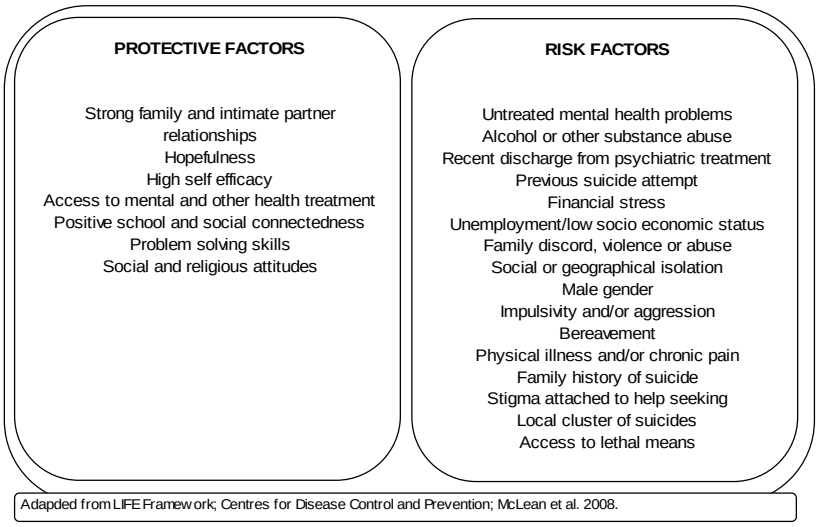
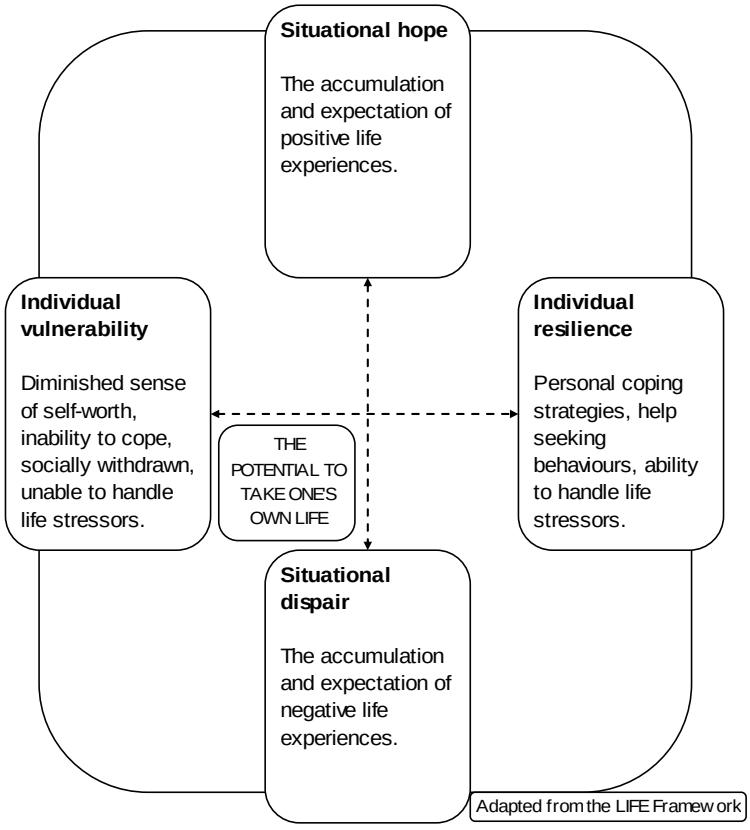


Figure 2: The relationship between individual vulnerability and situational despair in suicidal behaviour



Tipping points

Suicide is usually considered in response to difficulties or stresses that seem insurmountable to a person. Many stresses may be ongoing in a person's life, such as isolation or survival of abuse, and can contribute to an ongoing sense of hopelessness or marginalisation. This can reduce a person's resilience and increase their vulnerability.

Other stresses can occur suddenly. The point where the risk of a person taking their own life increases due to a specific precipitating event is referred to as a "tipping point". The person may not want to die but cannot see any other way to address their problems.

Examples of tipping points that are often cited by vulnerable people who actively consider suicide include the ending of a significant relationship, loss of status or respect, loss of employment, or the death of a relative or friend.

From the discussion above we can see that the potential to take one's own life results from a complex relationship between individual resilience, individual vulnerability, accumulated negative events and immediate crisis. Figure 2 illustrates the interrelationship of these factors.

Prevalence of suicide in the Australian population

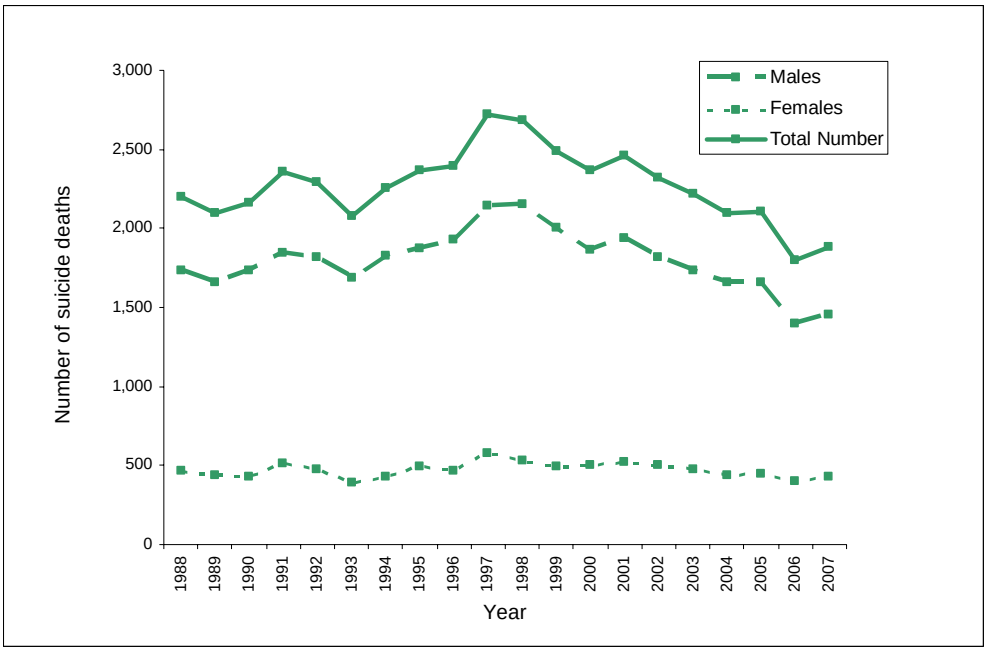
The Australian Bureau of Statistics (ABS) is the statutory authority responsible for the routine collation of data on suicide and other causes of death. The ABS adheres to strict coding rules for all data and no external parties, including members of the government or departments are privy to any of the data or deliberations prior to public release. It reports data annually on all registered deaths where there was sufficient information for coding at the time of processing. The latest data for 2007 was released in March 2009 and is in *Causes of Death, Australia, 2007*[1].

In 2007, there were 1,881 suicides registered representing an age standardised death rate of 9.0 deaths per 100,000 population.

The number of suicide deaths is slightly higher (by 82) than in 2006 and considerably lower than in 1997, when there were 18.7 deaths per 100,000 and the highest recorded number of suicides over the last two decades of reported data, with 2,720 suicide deaths registered.

Figure 3 shows the number of deaths by suicide recorded in Australia over the last 20 years and the lowering trend of recent years. It is acknowledged this decline has been associated with decreasing data quality in recent years, but there is also evidence that there have been decreases in suicides, particularly for some population groups. Data quality issues and efforts to improve data quality are discussed in Section 3.

Figure 3: Deaths by suicide in Australia by sex, 1988-2007



Source: Australian Bureau of Statistics[1]

Male suicides continue to outnumber female suicides, accounting for over three quarters or 77% of all suicide deaths in 2007 (Table 1).

Table 1: Deaths by suicide, 1998-2007

Year	Males	Females	Persons
1998	2,150	533	2,683
1999	2,002	490	2,492
2000	1,864	503	2,367
2001	1,936	521	2,457
2002	1,817	503	2,320
2003	1,737	477	2,214
2004	1,661	437	2,098
2005	1,658	444	2,102
2006	1,398	401	1,799
2007	1,454	427	1,881

Source: Australian Bureau of Statistics[1]

When growth in the population is taken into account, this decrease in the number of deaths by suicide represents an even greater decrease in the rate of suicide, with the reported rate halving over the ten years from 1998 to 2007 (Table 2).

Table 2: Rate of deaths by suicide per 100,000 population, 1998-2007

Year	Males	Females	Persons
1998	29.5	7.1	18.2
1999	27.2	6.4	16.6
2000	24.9	6.5	15.6
2001	25.5	6.6	15.9
2002	23.6	6.3	14.8
2003	22.2	5.9	13.9
2004	20.9	5.3	13.0
2005	20.5	5.3	12.8
2006	17.0	4.8	10.8
2007	13.9	4.0	9.0

Source: Australian Bureau of Statistics[1]

Comparisons with other causes of death in Australia

In 2007 there were 137,854 deaths registered. Of these 7,893 or 5.7% were due to external causes. These include transport accidents, poisonings, assaults, homicides and falls, as well as suicide. Suicide accounted for 1.4% of all deaths (Table 3).

Table 3: Deaths due to suicide, all deaths and proportion, 1998-2007

Year	Deaths due to suicide	All deaths	Suicide deaths as a proportion of all deaths in Australia (%)
1998	2,683	127,202	2.1
1999	2,492	128,102	1.9
2000	2,367	128,291	1.8
2001	2,457	128,544	1.9
2002	2,320	133,707	1.7
2003	2,214	132,292	1.7
2004	2,098	132,508	1.6
2005	2,102	130,714	1.6
2006	1,799	133,739	1.3
2007	1,881	137,854	1.4

Source: Australian Bureau of Statistics[1]

Intentional self-harm or suicide was ranked the 15th leading underlying cause of death for all those deaths registered in Australia in 2007 (Table 4).

Table 4: Leading causes of death among the Australian population, 2007

Leading underlying cause of death	Persons	Ranking
Ischaemic heart diseases (I20-I25)	22,729	1
Strokes (I60–I69)	11,491	2
Trachea and lung cancer (C33-C34)	7,626	3
Dementia and Alzheimer's Disease (F01-F03, G30)	7,320	4
Chronic lower respiratory diseases (J40-J47)	5,762	5
Colon and rectum cancer (C18-C21)	4,107	6
Diabetes (E10-E14)	3,810	7
Blood and lymph cancer (including leukaemia) (C81-C96)	3,603	8
Heart failure (I50-I51)	3,444	9
Diseases of the kidney and urinary system (N00-N39)	3,230	10
Prostate cancer (C61)	2,938	11
Breast cancer (C50)	2,706	12
Influence and pneumonia (J10-J18)	2,623	13
Pancreatic cancer (C25)	2,248	14
Suicide (X60-X84)	1,880	15
Skin cancer (C43-C44)	1,727	16
Hypertensive diseases (I10-I15)	1,627	17
Cirrhosis and other diseases of liver (K70-K76)	1,437	18
Cardiac arrhythmias (I14-I49)	1,397	19
Land transport accidents(V01-V89)	1,273	20

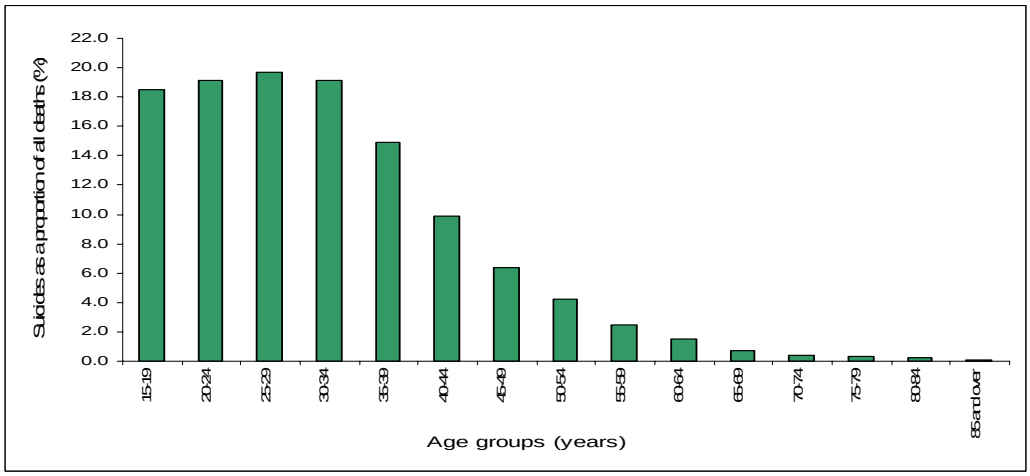
Source: Australian Bureau of Statistics[1]

Age variation

The median age at death for suicide in 2007 was 41.7 years for males and 44.5 years for females. This is in comparison to 77.5 for males and 83.5 for females for deaths from all causes.

While suicide is ranked as the 15th leading underlying cause of death registered in Australia and accounts for only a relatively small proportion (1.4%) of all deaths overall, it accounts for a much greater proportion of deaths in some groups of people (Figure 4). In particular suicide accounts for 21% of deaths for males aged under 35 years[1].

Figure 4: Deaths by suicide as a proportion of all deaths by age, 2007



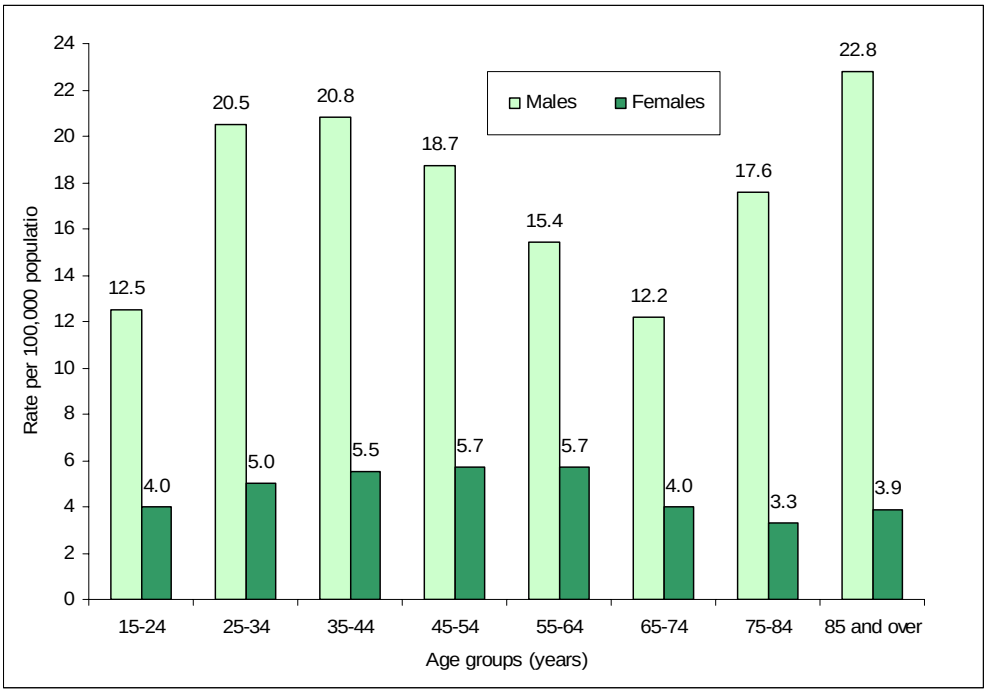
Source: Australian Bureau of Statistics[1]

As in recent years, in 2007 the highest age-specific suicide death rates for males occurred in those aged 85 years and over (22.8 per 100,000). However, suicide deaths were a relatively low proportion of total deaths (0.2%) in this age group due to the relatively high level of mortality by other causes (compare Figure 4). The higher proportion of deaths in younger age groups results from the fact that mortality from all other causes in these age groups is lower.

Figure 5 shows the age-specific suicide rates separately for males and females in 2007. Rates for younger males remained high in 2007, with the highest rates for males aged 25 to 34 years and 35 to 44 years (20.5 and 20.8 per 100,000 respectively). However, rates for young males aged 15-24 years (12.5 per 100,000) were low compared to men overall, as was the rate for 65-74 year olds (12.2 per 100,000).

For females, the age-specific death rates were highest for those aged 45-54 years and 55-64 years (both 5.7 per 100,000) and, by contrast to males, lowest for elderly females aged 75-84 years and 85 years and over (3.3 and 3.9 per 100,000).

Figure 5: Age-standardised suicide death rates per 100,000 population, 2007



Note: Deaths per 100,000 estimated resident population as of 30 June for each age group and sex.
Source: Australian Bureau of Statistics[1]

Means

Half of all deaths recorded as suicide in 2007 (54%) were due to hanging (including strangulation and suffocation). Poisoning by drugs was used in 12% of all suicides and poisoning by other methods, including by motor vehicle exhausts, was also used in 12% of all suicides. Methods using firearms accounted for 8.9% of suicide deaths (Table 5).

Table 5: Mechanism of death by suicide, 2007

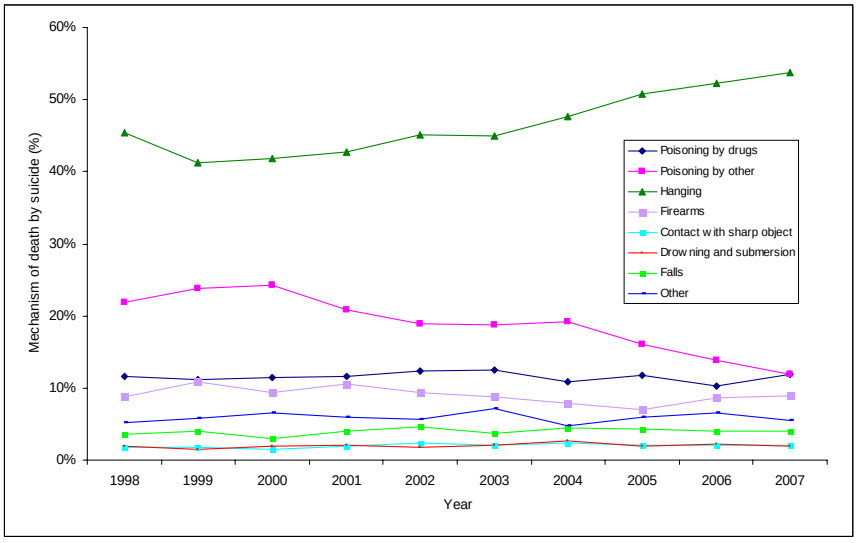
	Poisoning by drugs	Poisoning by other(a)	Hanging(b)	Firearms	Contact with sharp object	Drowning and submersion	Falls	Other(c)	Total
Males	93	184	826	160	32	19	57	83	1,454
Females	131	40	184	7	8	18	18	21	427
Persons	224	224	1,010	167	40	37	75	104	1,881

(a) Includes poisoning by other gases and vapours (including motor vehicle exhaust).
(b) Includes strangulation and suffocation.
(c) Includes explosives, smoke/fire/flames, blunt object, jumping or lying before moving object, crashing of motor vehicle, other and unspecified means. Also includes sequelae of intentional self-harm.
Source: Australian Bureau of Statistics[1]

Methods of suicide with a higher lethality, such as hanging or use of firearms, tend to be employed more often by men than women, which is an important factor in understanding the higher rates of suicides amongst men compared to women.

Over time there has been considerable change in the methods reported (Figure 6). When restrictions on firearms were introduced following the Port Arthur deaths in April 1996, there was a substantial decline in deaths due to this means. Firearm deaths have, however, increased proportionally in recent years. The greatest change has been the sustained increase in hangings and a similar decrease in poisoning by other means, which includes motor vehicle exhausts.

Figure 6: Proportion of suicide deaths due to various mechanisms, 1998-2007



Source: Australian Bureau of Statistics[1]

Distribution

Caution should also be exercised when comparing annual state and territory suicide rates, as considerable fluctuations over time are expected particularly in smaller jurisdictions due to the small numbers of suicides registered annually. It is thus more usual to look at several years of data and age-standardise this to take account of differences in the age profile of the states and territories.

Table 6 provides data on the number of suicides officially recorded in each state and territory for the last ten years of reported data. It highlights significant decreases in the numbers of deaths recorded in more recent years for larger states, particularly New South Wales and Queensland.

Table 6: Number of deaths by suicide by state/territory, 1998-2007

Year of registration	NSW	Vic.	Qld	SA	WA	Tas.	NT	ACT	Australia
1998	862	579	579	244	287	59	42	31	2,683
1999	869	552	480	200	236	78	32	45	2,492
2000	733	512	541	199	261	50	42	29	2,367
2001	785	541	500	208	270	64	43	46	2,457
2002	692	528	537	170	242	70	55	26	2,320
2003	640	540	466	193	227	69	44	35	2,214
2004	587	521	453	178	194	88	51	26	2,098
2005	549	506	459	231	203	74	45	35	2,102
2006	504	444	340	170	207	73	29	32	1,799
2007	551	438	285	202	254	66	54	31	1,881

Source: Australian Bureau of Statistics[1]

Annual age-standardised death rates for states and territories (Table 7) indicate that the suicide rates are relatively even across Australia with the exception of Tasmania (15.4 deaths per 100,000) and the Northern Territory (22.8 deaths per 100,000).

Table 7: Average annual age-standardised suicide rate by state/territory and sex, 2003-2007

	NSW	Vic.	Qld	SA	WA	Tas.	NT	ACT	Australia
Males	13.4	15.0	16.5	20.1	16.9	24.0	38.5	14.2	15.7
Females	3.5	4.5	3.9	5.0	4.7	7.5	6.1	5.1	4.2
Persons	8.3	9.6	10.1	12.4	10.7	15.4	22.8	9.4	9.8

Source: Australian Bureau of Statistics[1]

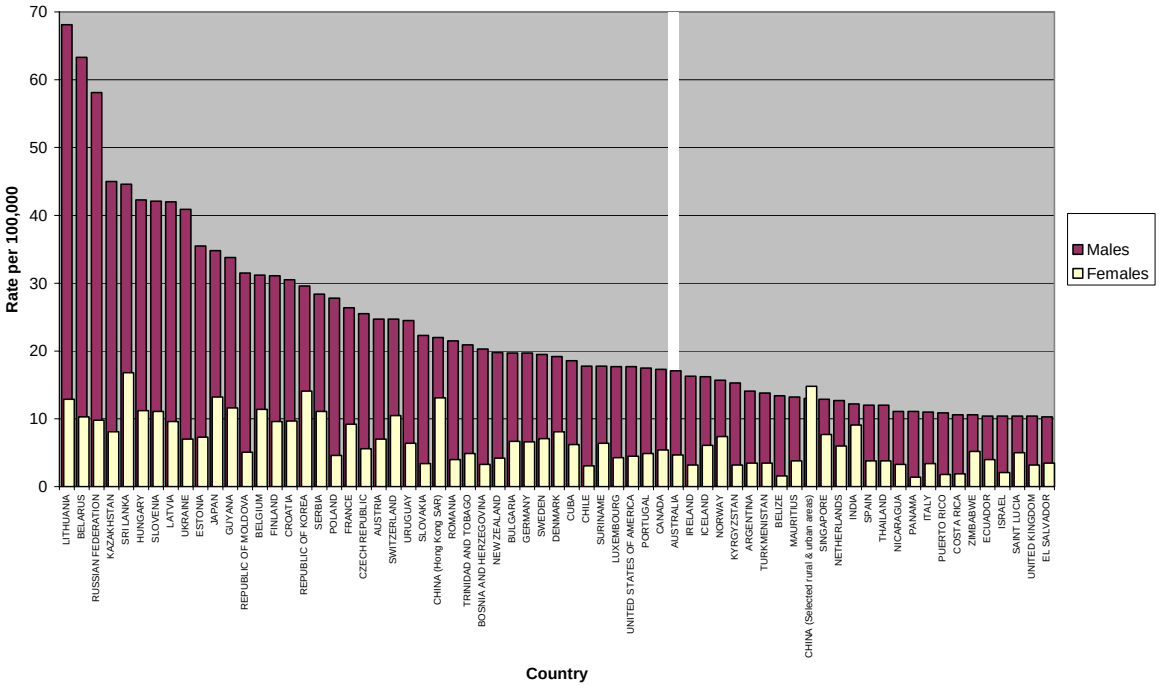
Considerable variation in the rates is also due to significant differences in data quality, specifically in the proportion of cases closed through finalisation of coronial processes. These are discussed in Section 3.

International comparisons

It is very difficult to compare the rate of suicide in Australia with that of other countries. This is not only because of differences in processes but also, even where other countries adhere to the international standards of reporting data according to the International Classification of Disorders Version 10, because of significant variations in the determination of suicide due to cultural and spiritual or religious differences.

While currency of data and collection methodology render international comparison difficult, Australia generally has a medium rate of death by suicide compared to other countries. Figure 7 compares rate by gender for selected countries. Australia is highlighted.

Figure 7: Comparison of Rates of Suicide in Selected Countries, Most recent data published by WHO (1990-2006)

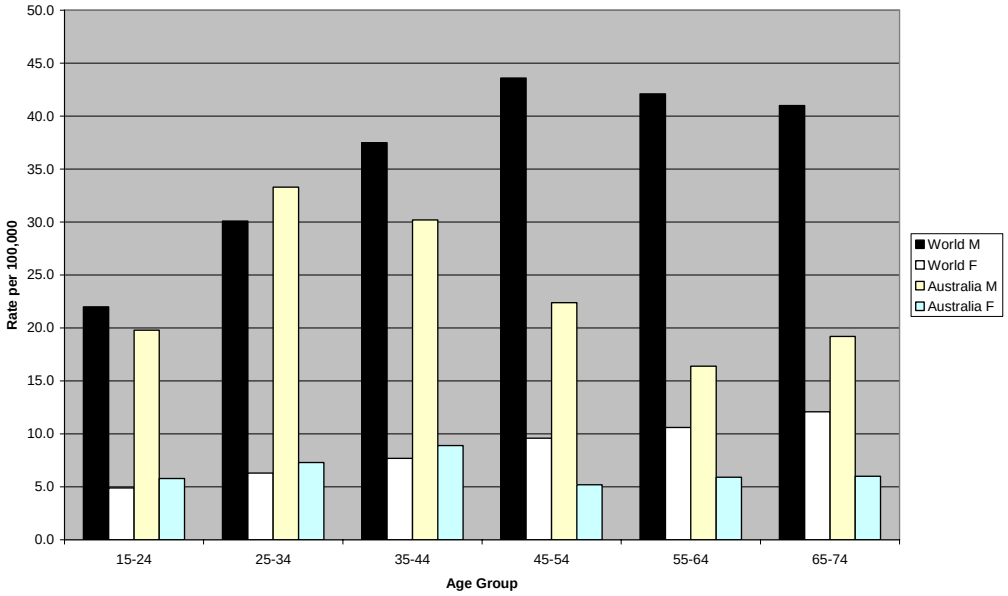


Source: WHO[24]

Analyses of data, such as those reported in International Suicide Rates and Prevention Strategies[6], indicate that the number of suicides and trends in the data reported in Australia over the previous three decades are generally consistent with those in other developed countries, particularly other 'New World countries', namely Canada, the United States and New Zealand.

A comparison of the most recent data from the WHO with ABS data from the same period is shown in Figure 8. As can be seen, rates of suicide in Australia are generally much lower than for the world population, with the exception of 25-34 year olds of both genders and 35-44 year old females. These areas of increase are small however and given the large discrepancies in data quality between members of the WHO should be read with caution.

Figure 8: Comparison of Rates of Suicide by Gender and Age, World and Australia, 2000



Source: WHO[24] and ABS[1].

3. ACCURACY OF SUICIDE DATA IN AUSTRALIA

- *There is general recognition that the official data on deaths registered as suicide in Australia each year underestimates the number of deaths by suicide that actually occur. The precise degree of underestimation is unknown.*
- *The number of deaths by suicide in Australia is likely always to have been underestimated. However there are suggestions that the extent of this underestimation may have increased over recent times.*
- *There are a number of remedial efforts involving a number of agencies and stakeholders to improve the accuracy of suicide data in Australia. DOHA is participating in these efforts and shares an interest in improved data in order to better target future suicide prevention efforts.*

Issues with the accuracy of suicide data in Australia

Australian Bureau of Statistics (ABS) mortality data are the main source of suicide statistics in Australia. The ABS is part of a complex process that generates these statistics. The other main part of the system is the National Coroners Information System (NCIS). Coding rules that form part of the International Classification of Diseases (ICD), which the ABS is required to apply, also affect the statistics.

Underlying the process are coroners themselves, who investigate deaths that might be due to suicide, come to conclusions about them, and write findings. Information is then fed from coroners to the NCIS and to death registers. Suicide is a cause of death that is especially subject to uncertainty and is often a sensitive matter. These factors are taken into account when coroners determine cases and record the findings of their investigations. While suicide statistics thus depend upon what coroners conclude and write, they are a by-product of their work. Enabling good quality mortality statistics is not a formal part of a coroner's role.

Coroners are also subject to jurisdictional laws and governance, which differ between each State and Territory. This can lead to differences in the way that suicides are recorded and reported between each jurisdiction.

Data quality

The ABS adheres to a transparent and prescribed process to ensure that causes of death data is accurately reported at the time of publication. In recent years, the ABS has cautioned users that suicide data may be underestimated and that 'observed changes over time are likely to have been affected by delays in [coroners] finalising a cause', the processing of these findings and differences in coronial reporting from one jurisdiction to another.

The ABS included extensive notes on the process for determining suicides and other technical issues in its publication of the 2007 data[1]. In these, it also noted, in general, reluctance by coroners to make a determination of suicidal intent, which is a necessary component for a determination of suicide. This is particularly true in cases of children and young people. Coroners may be influenced by sympathy with the feelings of family or sensitivity to cultural practices and religious beliefs when the evidence is not conclusive or insufficient. Legislation that governs the judicial coronial processes varies across states and territories and, in some cases, this and other regulatory barriers prohibit or limit the ability of coroners to make determinations of intent.

It is generally well acknowledged – including by the ABS – that the Causes of Death data under-reports the extent of suicide in Australia. Observations on the effects of methodological issues (case closures and procedural issues) on the reported data can be made and some analysis of this is provided below. However, it is not possible nor would it be appropriate to quantify the impact of coronial decisions on the suicide rate and, ultimately, to predict the number of suicides that would be recorded if there were sufficient evidence. Coroners operate within a judicial system, where they are intimately involved in the details of and evidence about individual deaths and the effects of these on the lives of others. Data on suicide is important, but is essentially an administrative by-product of these processes. The data do, however, continue to provide important and consistent evidence of the key at-risk populations and, in turn, where suicide prevention efforts should be targeted.

Many of the factors which contribute to undercounting of deaths by suicide are likely to have always impacted the accuracy of data. In this respect, the number of deaths by suicide is likely to always have been underestimated. However it is likely that undercounting has increased in recent years because of the increasing number of unclosed cases in which coroners have not yet made a decision about cause of death.

Effects of case closure

One of the key problems in recent years has been the increasing number of still pending decisions by coroners, that is 'open' cases, at the time the ABS must finalise the data for annual publication. This means that cases are not finalised and findings are not available in time for inclusion in the publication. Where intent has not been determined, deaths are coded to 'other accidental', 'ill-defined' or 'unspecified' causes rather than 'suicide' for the purposes of the ABS report.

The ABS first delayed the publication of the 2004 data by several months, which resulted in the publication date being moved from the usual, annual publication in November/December until March 2006. In spite of the ABS continuing to delay the annual closing date for processing data to around 13 months after the end of the year, the proportion of deaths that are closed continues to decline.

In total, 30.4% of all coronial cases remained open at the closing date for publication of the 2007 data. Approximately 12% of cases were certified by a coroner in 2007, and deaths by external and unknown causes are the bulk of those that remained open at the time of finalising the data (1.6% and 0.7% respectively of all cases). In total, 28% of all cases where there were external causes of death and 54% of all cases where there were unknown causes remained open at close of processing for the 2007 publication.

In 2006, there were 72.7% of cases closed at the close of processing for the ABS publication. When officers of the NCIS examined the 2006 data in May 2009, the number of cases closed had increased to 86%. Examination of the data found that there were 2,019 deaths reported to a coroner where the intent of the deceased was classed as 'intentional self harm'. This is 220 or 12.2% more than the 1,799 deaths recorded at the time of the data cut-off for the ABS publication of the 2006 data.

There are also significant variations in the case closure rates of states and territories varying from a low of 10.6% for the ACT through to a high of 72.3% in Queensland (Table 8). Overall, 30.4% of coronial cases had a status of open at the time of cut off for publication of the 2007 data.

Table 8: 2007 cases closed at 30 January 2009 by state/territory

	NSW	Vic.	Qld	SA	WA	Tas.	NT	ACT	Australia
Closed	3,595	3,388	825	1,593	1,416	384	228	294	11,723
Open	1,420	783	2,150	274	318	63	85	35	5,128
Proportion	28.3	18.8	72.3	14.7	18.3	14.1	27.2	10.6	30.4

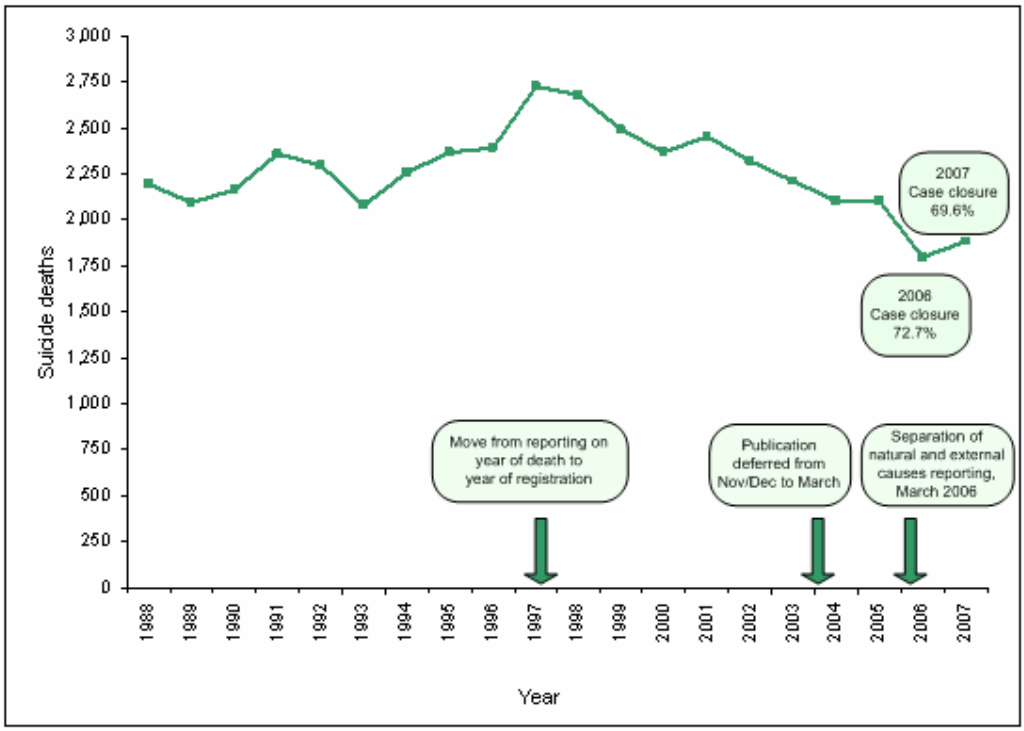
Source: Australian Bureau of Statistics[1]

These differences are clearly reflected in the pattern over time in the number of suicide deaths reported for respective states and territories, and to a lesser extent the variation in the rates between states and territories as shown in Table 7.

Recent initiatives to improve the quality of the data

The ABS has over time introduced a number of changes to the way it reports the data on suicides. Figure 9 identifies a number of changes in practice and other factors that have affected data quality and possibly the number of deaths reported as suicides.

Figure 9: Changes in reporting practices in relation to suicide rates, 1988-2007



Source: Australian Bureau of Statistics[1]

A major change in the reporting by the ABS is to be introduced with the next publication. The ABS has now agreed that all deaths registered after 1 January 2007 will be subject to a revision process. There will, for the first time, be an historical adjustment of suicide numbers beginning with 2007 data for publication in the March 2010 Causes of Death report. Revisions will be made on the data for three years. This readjustment will mean that, for the first time, more complete suicide data will be available to guide suicide prevention efforts. Estimates by the ABS suggest that around 90% of cases in a given year will in the future be covered by the report at the end of this revision process.

The ABS has formed a Mortality Statistics Advisory Group, which first met in 2008 to consider issues in relation to the reporting of Causes of Death data more generally. This brings together experts in the analysis of the data to provide advice in relation to the recent separation of reporting of natural and external causes, including suicide, and on the data revision process. DOHA is an active member of the Group.

Additional measures in relation to the collection of data around deaths and coding of the data have been identified through a number of other national and state-level initiatives and these are being progressed to further improve the quality and timeliness of the data. These include work with coroners and by the police to specify data collected and promote the use of standard forms in cases of possible suicide. Of particular note is the formation of the National Committee for the Standardised Reporting of Suicide by the peak body, Suicide Prevention Australia, which receives core funding from DOHA. This

has met on two occasions in 2009, bringing together representatives of coroners, forensic pathologists, registrars, the ABS, the NCIS, ASPAC, DOHA, and invited experts to consider ways to improve practices around the collection and reporting of suicide data. A major outcome of the group's work to date is a new shared understanding of the roles of the respective groups in producing data on suicide and an appreciation by police and coroners, on whom the quality of the data ultimately depends, of the importance of this to inform suicide prevention policies and investments. Work has also been referred to this group such as the development of national guidelines for coroners when considering the intent of an action that has resulted in the death of the actor. Other work such as the NCIS' trial of standardised police reporting protocols for examining the scene of a suspected suicide will potentially add to the work of this group.

DOHA recognises that the official data does not reflect the complete extent of death by suicide in Australia and the Department welcomes all efforts to increase the accuracy of reporting. However, it is not appropriate for DoHA to anticipate the outcome of the ABS technical revision of data collection processes and other work underway to improve suicide data in Australia by attempting to estimate the actual number of deaths by suicide in Australia.

4. SUICIDE PREVENTION IN AUSTRALIA

- *Suicide prevention is everybody's business.*
- *Whilst DOHA has primary responsibility for suicide prevention at an Australian Government level, other Australian Government agencies and State and Territory Governments play a key role in suicide prevention.*

The role of Australian Government and State and Territory governments in suicide prevention

Suicide prevention is everybody's business. Individuals, communities, businesses and governments all have roles and responsibilities in helping keep vulnerable people safe from suicide and self harm.

DOHA has primary responsibility for suicide prevention at an Australian Government level, as it has responsibility for the administration of the NSPP, the provision of mental health services through primary care and significant NGO support for the provision of alcohol and other drug services. However, other Australian Government agencies have roles to play, particularly where their client groups are at higher risk of suicide.

DOHA recognises that it is important that suicide prevention activities across areas of the Australian Government are complementary and coordinated. The inclusion of suicide prevention on the agenda for the Mental Health Interdepartmental Committee has ensured that at a senior official level, portfolios are able to support each other's suicide prevention efforts.

Examples of other Australian Government agencies' activity which is relevant to suicide prevention include the Department of Veteran's Affairs training for peer support of suicidal veterans through Operation Life which offers Applied Suicide Intervention Skills Training (ASIST) to veterans, or the support provided through Family Relationship Centres to help families manage and resolve conflict.

The Department of Education, Employment and Workplace Relations (DEEWR) also administers a number of services to assist people with mental illness and those at risk of suicide, including:

- Job Services Australia, which provides a single entry point to a range of employment services for job seekers, including those with mental illness;
- Disability Employment Services (commencing from 1 March 2010), which will provide flexible, tailored employment assistance for eligible job seekers and workers with disability, including mental illness; and
- Youth Connections, which will provide an improved safety net for young people who have disconnected from education or their community, or are at risk of disengaging.

Furthermore, of the 350,000 Australians assisted by, Centrelink social workers in 2008, 3,463 were referred as a result of being at risk of suicide and 30,650 more broadly with 'mental health issues'.

It is understood that these portfolios may themselves be presenting evidence and/or submissions to the Inquiry.

State and Territory governments have a range of suicide prevention strategies, policies, plans and programs that operate within their jurisdiction. Many of them are based on the LIFE Framework and its action areas, which assists inter-jurisdictional discussions about suicide prevention. State government investment in the specialist mental health system, particularly for people with severe and persistent mental illness, is very relevant to their suicide prevention efforts. People with severe mental illness are at heightened risk of suicide, and specialist crisis services are funded by states and territories to respond to individuals who have attempted suicide. State and territory investment in hospital Accident and Emergency Services also supports services to individuals who have attempted suicide.

Australian Government investment in suicide prevention efforts

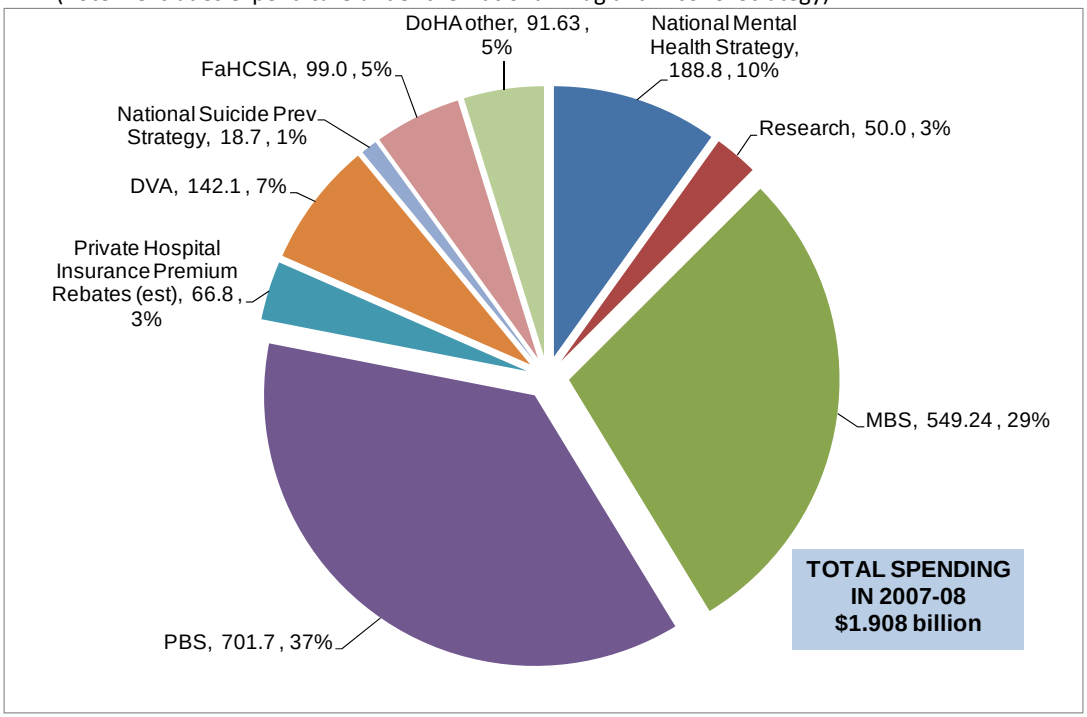
The Australian Government's suicide prevention efforts are in no way confined to the specific expenditure under the NSPP. Specific spending under the NSPP is detailed in the following sections. Mental health services and programs, broader health initiatives such as indigenous health programs, and drug and alcohol support also comprise an important platform from which DOHA administered programs contribute to efforts to prevent suicide and support people at risk of suicidal behaviour. Other Government portfolios similarly administer a broad range of mainstream programs which contribute to supporting individuals at risk and protecting against factors which may be associated with suicidality.

The single biggest risk factor for suicide is the presence of a mental disorder – so services which aim to either prevent, intervene early or effectively treat mental disorder will therefore contribute to a reduction in self harm behaviour and suicide. A full list of current Australian Government investment in mental health through programs administered by DOHA is provided at 0.

To date, the majority of Australian Government investment in prevention of suicide and helping people with a mental illness manage their suicidality has been through improving access to appropriate mental health services and medication particularly through primary care and through additional mental health support services and programs. There has been a substantial expansion of investment by the Australian Government in mental health services and programs particularly since the COAG mental health package in 2006.

According to the most recent Review of Government Services (ROGS) report, investment in mental health services and programs by the Australian Government in 2006-07 was $1.6 billion. More recent data compiled for the forthcoming ROGS report indicates that expenditure on mental health specific activities and programs increased to $1.9 billion in 2007-08 (Figure 8). Whilst 1% of funding is directly contributed to the NSPS, a large amount of funds are provided for programs which support suicide prevention efforts.

Figure 8– DOHA mental health expenditure in 2007-08. Source: Department of Health and Ageing (note – excludes expenditure under the National Drug and Alcohol Strategy)



Programs and services which play a significant role in upstream support for people who may be at risk of suicide include:

- Mental health services provided under the MBS and through other programs such as ATAPS which have targeted better detection and management of mental illness;
- Better training for mental health professionals;
- Investment in mental health promotion and prevention activities, including the National Depression Initiative through which beyondblue is funded;
- Mental health programs targeting particular groups who are at higher risk of suicide including the Mental Health Services for People in Rural and Remote Areas initiative, and indigenous specific mental health programs;
- Early intervention programs such as headspace, which provides holistic youth friendly services targeting the needs of young people with or at risk of mental illness;

- A focus on better supporting mental health outcomes for children and parents in the early years of life through funding for the Perinatal Depression Initiative which screens for mental illness, and initiatives such as KidsMatter Early Childhood; and
- Expanded telephone and web based crisis support and self help therapies through programs such as Mood Gym, Kids Helpline, Panic On-line, Depressionet, Crisis Support Services and Lifeline, which have promoted the availability of confidential and accessible advice and resources.

Given the high correlation between suicidality and drug and alcohol misuse, the Australian Government's investment in the National Drug and Alcohol Strategy is extremely relevant to suicide prevention efforts. Expenditure on alcohol and other drug strategy activities has increased by over 80% in the last five years, from $105.1m in 2004-05 to $190.9m in 2008-09. This investment is summarised at APPENDIX C. Broader investment in Indigenous health programs, including social and emotional wellbeing activities also contributes to suicide prevention efforts targeting Aboriginal people and Torres Strait Islanders. The Australian Government has invested $78.463 million during 2009-10 through a range of initiatives, details of which are provided at 0.

5. THE NATIONAL SUICIDE PREVENTION STRATEGY

- *Australia was one of the first countries in the world to develop a dedicated National Suicide Prevention Strategy.*
- *The National Suicide Prevention Strategy has evolved over time in response to formal evaluations and emerging evidence in suicide prevention.*
- *The National Suicide Prevention Strategy is guided by the LIFE Framework that provides a strategic policy framework for suicide prevention in Australia.*
- *Funding for the National Suicide Prevention Strategy – delivered through the National Suicide Prevention Program – has steadily and significantly increased since the establishment of the National Youth Suicide Prevention Strategy in 1995.*
- *Expert advice on the strategic direction of the National Suicide Prevention Strategy and Program is provided to the Minister for Health and Ageing by the Australian Suicide Prevention Advisory Council.*

The Four Components of the National Suicide Prevention Strategy

The current National Suicide Prevention Strategy (NSPS) has four key inter-related components:

- The Living Is For Everyone (LIFE) Framework, which sets an overarching evidence based strategic policy framework for suicide prevention in Australia;
- The National Suicide Prevention Strategy Action Framework, which provides a time limited workplan for taking forward suicide prevention investment and leverage;
- The National Suicide Prevention Program (NSPP), which is the Australian Government funding program dedicated to suicide prevention activities; and
- Mechanisms to promote alignment with and enhance state and territory suicide prevention activities, particularly to progress the relevant actions of related national frameworks, such as the COAG National Action Plan for Mental Health 2006-2011[6] and the Fourth National Mental Health Plan 2009-14[26].

Governance for the Strategy is supported through the Australian Suicide Prevention Advisory Council (ASPAC), which was established by the Australian Government in 2008 to provide national leadership and strategic advice to the Minister for Health and Ageing on suicide prevention issues.

Alignment efforts are supported through the National Mental Health Standing Committee, which includes representatives of all state and territory health departments together with the Australian Government, and reports to the Australian Health Ministers Advisory Council (AHMAC).

The Goals and Objectives of the NSPS

The NSPS is a program under the COAG National Action Plan for Mental Health 2006-11[6]. The five year goal of the NSPS is to reduce deaths by suicide across the population and among at risk groups and to reduce suicidal behaviour by:

- Adopting a whole of community approach to suicide prevention to extend and enhance public understanding of suicide and its causes;
- Enhancing resilience, resourcefulness and social connectedness in people, families and communities to protect against the risk factors for suicide; and
- Increasing support available to people, families and communities affected by suicide or suicidal behaviour.

The objectives of the NSPS and broad strategies through which they have been effected are presented below in Table 10.

Table 9 Objectives of the NSPS and Strategies to Achieve them.

OBJECTIVE	STRATEGIES
1. *Enhance protection against suicide* – to protect against suicidal behaviour, through preventative measures and by promoting wellbeing, optimism and social connectedness;	Many of the NSPS activities outlined in Section 6 of this submission are designed to build protective factors such as resilience and optimism particularly among children and youth. Examples of these interventions are the MindMatters and KidsMatter school based initiatives. A number of community based programs outlined within the 'Selective Interventions' part of Section 7 also target this objective. These projects and activities promote networks and connections, and are aimed at building the protective factor of social connectedness particularly among groups such as older men, and reducing isolation associated with higher risk of suicide.
2. *Improve early identification and intervention* – to better identify and help people at risk of suicide by improving community attitudes, understanding and awareness;	Frontline training activities which have targeted a range of sectors and population groups have aimed to improve identification and early intervention. Examples include training for undergraduate journalists and teachers through ResponseAbility, the Family Court project, and training for GPs and allied health professionals in suicide prevention issues.

OBJECTIVE	STRATEGIES
3. *Improve crisis support and care* – to improve support and care for people who have attempted suicide;	Whilst the majority of crisis support and care is provided through the broader mental health system (funded through both Australian Government and State/Territory services), indicated interventions described in Section 7 of this submission focus on improving support to individuals during and after a crisis. In particular the new ATAPS suicide prevention demonstration project aims to improve followup care and support in the aftermath of a suicide or self harm attempt. Alignment with state and territory suicide prevention activity, and continuing cross sectoral activity to promote better understanding of suicide prevention amongst frontline providers including emergency services and police will also advance this objective.
4. *Ensure support after a suicide* – to give effective support to those who are bereaved or affected by suicide, and to reduce the potential for further suicides; and	Bereavement support activities at a national and local level are described in Section 7 of this submission. These aim to give support to families and other individuals bereaved by suicide and to reduce the risk of further suicides. The Standby project is an example of an intervention in this area.
5. *Build the evidence base* – to improve information about the prevalence and causes of suicide in the population, to inform people of effective suicide prevention activities and to monitor the implementation of the strategy.	New infrastructure including funding for the National Centre of Excellence for Suicide Prevention based at the Australian Institute of Suicide Research and Prevention is providing a foundation for collecting evidence from Australia and overseas (refer Section 8). Specific research projects funded under the NSPS and broader research funded through the NHMRC is also supporting development of an evidence base. The result of the evaluations of the Strategy, its components and individual projects will also feed into improving knowledge and understanding of suicide prevention strategies and actions.

Brief History of the NSPS

Australia was one of the first countries to establish a specific national suicide prevention strategy and accompanying dedicated program of funding. Initially the focus was on youth suicide.

In the 1995-96 Federal Budget $13 million was allocated over four years to develop and implement a national plan for youth in distress. In the following year, a further $18 million was allocated to the National Youth Suicide Prevention Strategy (NYSPS), with a total of $31 million allocated between 1995 and 1999. The NYSPS was evaluated by the Australian Institute for Family Studies[32] and has been favourably reviewed in health promotion literature[14].

In 2000, the National Youth Suicide Prevention Strategy was expanded into the NSPS with a broader agenda across the whole life course. This year also saw the development of the first iteration of *Living Is For Everyone: A Framework for Prevention of Suicide and Self-harm in Australia* (LIFE Framework). It provided a strategic framework for national action to prevent suicide and promote mental health and resilience across the Australian population, within the NSPS.

The 2006-07 Federal Budget committed to the Australian Government component of the COAG National Action Plan for Mental Health 2006-2011[6]. This was a total package of new funding totaling $1.9 billion over five years including $62.4 million to expand the NSPP to a total of $127.1 million between 2006-07 and 2011-12. This increase in investment coincided with a major revision of the LIFE Framework, which is discussed in detail below.

The LIFE Framework

In 2000, the *Living Is For Everyone: A Framework for Prevention of Suicide and Self-harm in Australia* (LIFE Framework) was released. That framework provided a strategic plan for national action to prevent suicide and promote mental health and resilience across the Australian population. It has played an important role in providing research, evidence and information about suicide and suicide prevention internationally and within Australia, and it remains an important source document.

In early 2006, an independent review and consultation with key stakeholders on the LIFE Framework was commissioned. This consultation found that the Life Framework resources were individually useful, but very dense and hard to navigate, and not broadly utilized within the community at that time. As a result of that review a redevelopment of the LIFE Framework was commissioned in 2007. The new framework was developed after extensive consultations from November 2006 to June 2007.

These consultations involved the wider Australian community and included representatives from national and state government departments, academics and researchers; health and community service professionals; peak bodies and service providers in the public and non government sectors; local communities, services and recreation clubs; special interest groups; people bereaved by suicide; and families, friends and individuals. The consultations were supplemented by a wider canvassing of the most recent international and national research.

At present, the LIFE Framework forms the strategic basis for suicide prevention activity and investment by DOHA. The LIFE Framework has also been used by many State and Territory governments as the basis for developing their own suicide prevention strategies, policies and plans.

The four broad goals of the LIFE Framework are to:

- reduce deaths by suicide across all age groups in the Australian population, and reduce suicidal thinking, suicidal behaviour, and the injury and self-harm that result;
- enhance resilience and resourcefulness, respect, interconnectedness and mental health in young people, families and communities, and reduce the prevalence of risk factors for suicide;
- increase support available to individuals, families and communities affected by suicide or suicidal behaviours;
- provide a whole of community approach to suicide prevention and to extend and enhance public understanding of suicide and its causes.

The LIFE Framework identifies six Action Areas. Each Action Area has a variety of outcomes and associated strategies. The six Action Areas are:

- Improving the evidence base and understanding of suicide prevention;
- Building individual resilience and the capacity for self-help;
- Improving community strength, resilience and capacity in suicide prevention;
- Taking a coordinated approach to suicide prevention;
- Providing targeted suicide prevention activities; and
- Implementing standards and quality in suicide prevention.

The LIFE Framework also recognises that successful suicide prevention activity provides interventions across a continuum that support people at different points of suicide risk: universal, selective and indicated interventions.

Universal Interventions aim to engage the whole of a population to reduce access to means of suicide, reduce inappropriate media coverage of suicide and to foster stronger and more supportive schools and communities.

Selective interventions aim to work with groups and communities who are identified as being at higher risk of suicide due to a clustering of risk factors, in order to build resilience, strength and capacity - such as bereavement support, working with low socioeconomic status men, or working in communities with higher rates of suicide.

Indicated Interventions aim to target people who are showing signs of suicidality, present symptoms that are strongly associated with suicide (such as depression or alcohol dependence) or in circumstances that place them at high risk of suicide (such as discharge from hospital).

The National Suicide Prevention Action Framework

The Australian Suicide Prevention Advisory Council (ASPAC) – appointed in 2008 – has, in collaboration with DOHA, developed an Action Framework to guide the Australian Government's strategic directions and priorities in suicide prevention and self-harm for the period 2009-2011.

This will effectively steer the NSPS and NSPP until the end of the current period of funding under the COAG National Action Plan for Mental Health 2006-2011[6]. The results of the next evaluation, that is anticipated will cover the COAG period, coupled with continuing efforts by many individuals and organisations to continually improve suicide data, will ensure we can continually learn how to improve our investments in suicide prevention and inform the direction of the NSPS and NSPP after 2011. ASPAC and DOHA work together through the implementation of the Action Framework to provide national leadership in suicide prevention activity and policy.

The current Action Framework describes the activities to be undertaken by ASPAC and DOHA to June 2011 to progress the Australian Government's suicide prevention efforts. It has two primary purposes:

- To help ASPAC plan and manage the provision of confidential advice to the Australian Government through the Minister for Health and Ageing on strategic directions and priorities in relation to suicide prevention and self-harm; and,
- To help DOHA plan and manage the implementation of the NSPP for 2009-10 to 2010-11.

The Action Framework has been developed and will be implemented in line with the key principles described in Table 9.

Table 10: Principles for the National Suicide Prevention Program Action Framework 2009-2011

Principle	
Alignment:	To be most effective, suicide prevention policy and program activity should be actively aligned across government portfolios and jurisdictions.
Leverage:	Specific suicide prevention policy and program activity is more effective when it leverages off other related social policy and program activity, both within the Australian Government Health and Ageing portfolio, but also across other Australian Government and State and Territory government portfolios.
Embeddedness:	Suicide prevention is a whole of community responsibility and can be successfully embedded in approaches to everyday activity across the whole community, especially where people work in communities or with individuals who are at higher risk of suicide.
Universal Suicide Prevention Activity	A comprehensive response to suicidality across the whole community needs to include population based, universal suicide prevention activity.
Selected and Indicated Suicide Prevention Activity	A comprehensive response to suicidality needs to recognise that some communities and population groups are at higher risk of suicide than the general population. This understanding means that selected activity needs to support communities and population groups at higher risk of suicide, and indicated interventions are necessary for people at high risk of suicide.
National and local	Suicide prevention policy and program activity needs to be developed with a balance of nationally applicable and consistent activity, and local activity that reflects the suicide prevention requirements of particular communities.
Evidence, data and evaluation	Suicide prevention policy and program activity needs to be developed with consideration of the best evidence, acknowledging that the accuracy of suicide data needs to be improved, and policy and program activity needs to be regularly evaluated for effectiveness.

The National Suicide Prevention Program (NSPP)

DOHA administers the NSPP within the LIFE Framework. Investment under the NSPP is directed towards two distinct but important dimensions. The first is investment across the continuum from universal population level interventions to more targeted interventions. The second dimension of investment relates to the need for strategies at both a national and local level.

A continuum of suicide prevention activity across universal, selective and indicated interventions is necessary to ensure the greatest possible impact on suicidal behaviour at

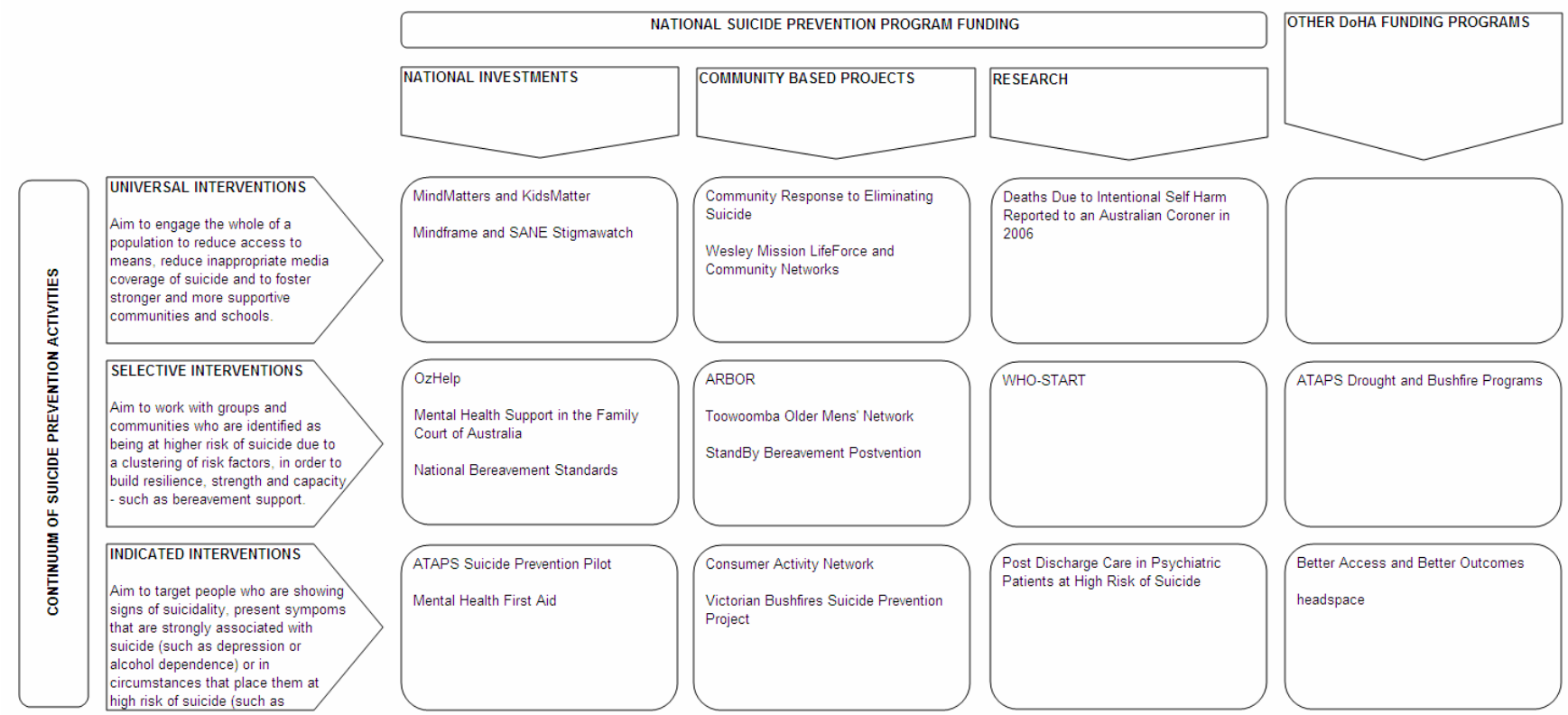
the whole of population level as well as helping those groups and individuals that are at higher risk of suicide.

In considering project funding under the NSPP, there is a need to support nationally consistent approaches to some issues, and to underpin actions through national research and infrastructure. A key premise underpinning the history of investment has been to encourage local, community based responses to problems that harness available capacity and national knowledge to build locally effective solutions.

Figure 10 illustrates the relationship between the continuum of suicide prevention activity and the national to community based scale of projects, and provides some examples of projects that have been funded that meet each particular need.

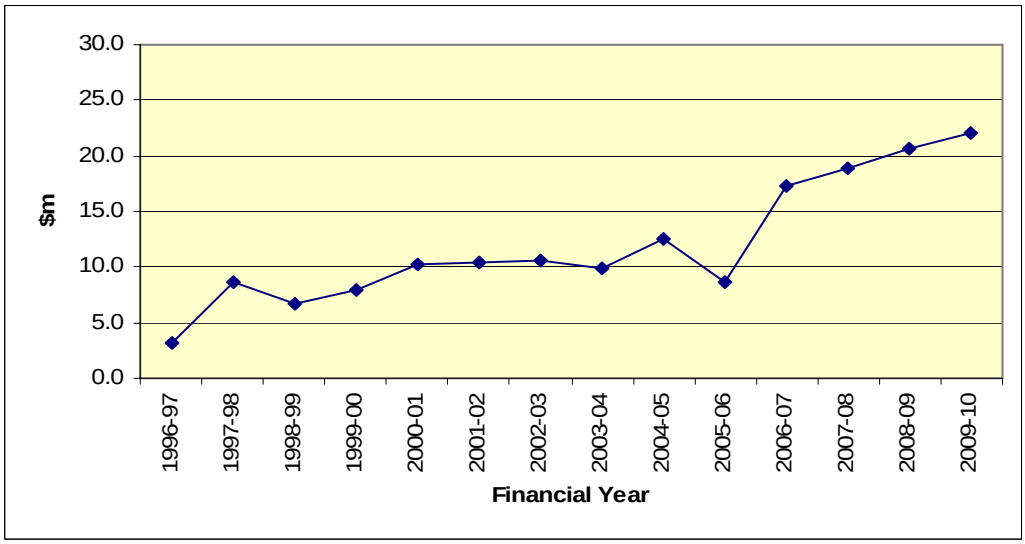
A complete listing of current projects, including details about models of activity and recent achievements is included at APPENDIX D.

Figure 10: Examples of NSPS funded national projects, community based projects and research as well as other DoHA administered programs across the continuum of suicide prevention activities.



Since the National Youth Suicide Prevention Strategy (NYSPS) was announced in 1996-97 until 2009-10, DOHA has had responsibility for $167.7m worth of appropriations for the NYSPS and the NSPP. The figure below illustrates the distribution of the appropriation over the financial years 1996-97 to 2008-09. It is clear from this figure that investment by the Australian Government in suicide prevention has increased significantly over the last decade, and that there has been no reduction of effort despite the decline in official data on deaths by suicide.

Figure 11: Appropriations by Financial Year for National Youth Suicide Prevention Strategy (1996-97 to 1998-99 and NSPP (1999-00 to 2009-10)



Mechanisms to promote alignment with state and territory suicide prevention activities

The area of alignment and enhancement of Commonwealth and state/territory suicide prevention activity is a significant challenge. Considerable effort has gone into jointly planning Australian Government suicide prevention investment with states and territories, particularly under the COAG National Action Plan for Mental Health 2006-11[6], and work has begun towards a single national suicide prevention framework.

The last few years have seen an increasing level of cooperation between the Australian Government and State and Territory governments in the area of suicide prevention. The commitment to suicide prevention in the COAG agenda led to discussions on suicide prevention to be included in the COAG State and Territory Working Groups. Although this started off slowly, it has gained momentum more recently. A few key examples are:

- Pilot sites for the Access to Allied Psychological Services (ATAPS) Suicide Prevention Pilot were determined in consultation with State and Territory Directors of Mental Health to ensure the pilots were located in areas of higher suicide rates but which also had State and Territory health system structures in place that were best able to support the pilot (further detail on this project is included at pp.62); and

- State and Territory Directors of Mental Health were consulted in the process for continuation of community based projects under the NSPP to ensure that the projects DOHA was considering funding were of continued appropriateness to the mix of suicide prevention activities in each jurisdiction. In jurisdictions where there has been capacity for moderate new activity under the NSPP, State and Territory Directors have also been consulted in determining locations and target groups that are most in need for support in their jurisdiction.

With the recent endorsement of the Fourth National Mental Health Plan[26]: an agenda for collaborative government action in mental health 2009-14, a commitment has been made towards achieving alignment and improvement of suicide prevention activity, and action is already underway with jurisdictions towards establishing an agreed national framework. Arrangements are also being put into place for the progression of activity against the suicide prevention actions listed. These are:

- Provide education about mental health and suicide prevention to front line workers in emergency, welfare and associated sectors; and
- Coordinate state, territory and Commonwealth suicide prevention activities through a nationally agreed suicide prevention framework to improve efforts to identify people at risk of suicide and improve the effectiveness of services and support available to them.

A number of states and territories have adopted the LIFE Framework as the basis of their suicide prevention activities and investment. Most recently, discussions have begun with State and Territory Directors to progress the adaptation of the LIFE Framework through the Mental Health Standing Committee (MHSC) to take on a role as a truly nationally agreed framework for suicide prevention.

The MHSC has agreed to the formation of a time limited Working Group comprised of jurisdictional members of the MHSC and Commonwealth representatives to progress activity and it is anticipated that an initial meeting will take place before the end of 2009.

The Australian Suicide Prevention Advisory Council (ASPAC)

On the 12 June 2008, the Minister for Health and Ageing announced the establishment of the ASPAC at the Grace Groom Lecture in Canberra. A copy of the Council's membership and terms of reference are at APPENDIX E. The Minister noted that the, "new Advisory Council will support a renewed focus on suicide prevention, and will bring together key community experts from diverse backgrounds and experience but with a shared commitment to suicide prevention. This will help ensure that the investments that are being made impact where they are needed most and in a way that is responsive to, and has the support of, the wider community".

On 10 September 2008, World Suicide Prevention Day, the Minister announced the formal membership of the ASPAC, advising that the Council would be chaired by Professor Ian Webster AO, Emeritus Professor of Public Health and Community Medicine

at the University of New South Wales. The membership of ASPAC brings together high level expertise in suicide prevention in Australia, with members representing academia, service providers, consumers and coronial process.

The objective of the ASPAC is to provide confidential advice to the Australian Government through the Minister for Health and Ageing on strategic directions and priorities in relation to suicide prevention and self-harm in order to support the Australian Government's implementation of the NSPP.

The Council has met on four occasions since its inception, with the inaugural meeting held in November 2008 and the most recent meeting in September 2009. Over the last 12 months the ASPAC has considered a number issues and priority areas, and has provided advice to the Minister accordingly. Key areas of current focus include:

- The provision of advice on the objectives and priorities for the NSPP beyond June 2009. In collaboration with DOHA, this advice has led to the development of an Action Framework for the NSPP for 2009-2011;
- Consideration of principles to guide the Government in its consideration of continued funding for the community-based projects under the NSPP;
- The issue of suicide in Aboriginal and Torres Strait Islander communities, and the development of formal linkages with the Indigenous Strategies Working Group;
- The issue of male suicide and the plans to undertake focussing to identify the sub-groups at most risk within the male population;
- The need to continue to provide targeted interventions that support population groups at higher risk of suicide;
- Advice on work currently being undertaken to improve suicide data quality and the processes that underpin data collection and reporting;
- The need to strengthen the provision of support to people with a mental illness recognising that they are a group at greater risk of suicide; and
- The potential impact of the global financial crisis on the mental health and wellbeing of the Australian community.

Since its inception, the Council has formed a series of working groups to progress research and resource development projects that will strengthen the policy advice provided by the Council and will help inform the development of targeted and universal suicide prevention initiatives under the NSPP. Current projects being developed include:

- The development of a community plan for the prevention and containment of suicide clusters;
- A research project to identify high risk indicators and high risk groups for suicide within rural and remote communities;
- An examination of the mechanisms that are currently implemented to respond to people at imminent risk of suicide across Australia and the avenues of care available to them once they have made contact with the health care system; and
- The development of evidence-based guidelines for governments and agencies on action that can be taken to manage and prevent suicides at suicide 'hotspots'.

6. UNIVERSAL INTERVENTIONS IN SUICIDE PREVENTION

- *Universal interventions aim to engage the whole of a population to reduce access to means of suicide, reduce inappropriate media coverage of suicide and to foster stronger and more supportive communities and schools.*
- *Universal interventions formed the basis of much early work in Australia under the National Youth Suicide Prevention Strategy and earlier iterations of the National Suicide Prevention Strategy.*
- *Universal interventions to improve media coverage of suicide and mental health and to embed mental health promotion in school communities have been very successful in Australia.*
- *While there is a recognised need for universal interventions to be supported by selective and targeted interventions for communities and individuals at higher risk of suicide, it is important that we do not reduce our commitment to maintaining good universal intervention.*

Universal interventions that engage the whole community are important elements of any suicide prevention strategy. Early in the development of the National Youth Suicide Prevention Strategy and later the NSPS and NSPP, a significant emphasis was placed on universal interventions including school based mental health promotion projects and media reporting guidelines projects. These types of interventions remain important today, and are complemented by a much broader range of selective and indicated interventions.

The efforts of the NSPS have both informed and been complemented by broader mental health promotion programs and initiatives, funded under other Commonwealth mental health programs. These initiatives include the National Depression Initiative, mental health promotion activities funded under the National Mental Health Program, and elements of the Youth Mental Health Initiative, including headspace, which promotes mental health literacy and help seeking by young people. In addition the Australian Government funds suicide prevention research and sector infrastructure as detailed in Section 8.

Nationally funded universal programs

Two of the most enduring universal approaches to suicide prevention in Australia are:

- the implementation of an integrated media strategy, including the development of media reporting guidelines to reduce the stigma of mental illness, encourage help seeking and reduce copycat suicide; and
- the development of school based projects that help schools build strong, supportive communities and individual students to develop personal resilience, mental health literacy and help seeking behaviours.

The Commonwealth also invests in projects which aim to reduce suicides at a population level. This includes the development of guidelines and recommendations to prevent suicides at suicide hotspots.

Through the NSPP, DOHA administered over $5.2million during 2008-09 to projects which took a universal approach to suicide prevention.

Media – the Mindframe Initiative

Mental health and suicide prevention in the media

Research in Australia and overseas has shown that the way the media report about suicide and mental illness can influence public and private attitudes about these issues[4]. Numerous studies have shown that news reports of suicide can lead to imitation acts, particularly when the report is prominent, glamorises or sensationalises suicide and/or describes the method of suicide in detail[5]. Print media reporting, as well as film, radio, television and theatre can also strongly influence community beliefs about mental illness and suicide, contributing to related stigma and myths.

The WHO acknowledges the importance of appropriate and sensitive media reporting about suicide. The WHO's *Preventing Suicide – A Resource for Media Professionals*[27] provides general guidance to media professionals on responsible reporting, noting that media professionals should utilise local, culturally-appropriate guidelines where possible.

In Australia, the Mindframe National Media Initiative (Mindframe Initiative) funded through the NSPP, is the primary source of guidance for media professionals and persons who interact with the media. The Initiative was developed by the Australian Government in 2000 following a review of the previous set of resources called 'Achieving the Balance'.

The aim of the Mindframe Initiative is to encourage responsible, accurate and sensitive media representation of mental illness and suicide, and to advocate on behalf of community concerns about media depictions that stigmatise mental illness or promote self-harm. The Initiative includes a suite of projects which include:

- The Hunter Institute's Mindframe resources for media professionals, mental health and suicide prevention sector workers, stage and screen writers and police and court officials;
- Stigmawatch;
- The National Media and Mental Health Group which has brought together representatives of the media with mental health professionals and the Commonwealth to develop strategies for improving media understanding and reporting of suicide and mental illness.

Collectively these activities have focussed on providing resources and education opportunities for media professionals, and facilitating the inclusion of these in tertiary journalism education, the mental health and suicide prevention sector, police and courts, and those involved in the development of Australian film, television and theatre.

The Mindframe initiative was developed in consultation with the media industry, mental health promotion and suicide prevention experts, policy makers, police and courts in each state and territory and people directly affected by mental illness. The resources are supported by peak media organisations such as the Australian Broadcasting Corporation, News Limited, the Australian Press Council, Free TV and SBS, as well as suicide prevention and mental health organisations represented by the National Media and Mental Health Group.

More detail on the individual components of the Mindframe Initiative, and current membership of the National Media and Mental Health Group is provided at APPENDIX F.

Media Monitoring Project

Two key studies have been commissioned by the Australian Government through the Media Monitoring Project to track reporting of suicide and mental illness in the Australian media over a 12-month period: the first during 2000-2001 and a follow-up study from September 2006 to August 2007. The second study was able to draw comparisons in media reporting between the two time periods.

The second study under the Media Monitoring Project found that there was a marked increase in the overall volume of media items on suicide and mental health across all media. More importantly it also found that, almost without exception, there was a significant improvement in the quality of media reporting of suicide and mental illness across Australia. The results of the project demonstrate the effectiveness of the Mindframe Initiative projects and their resources.

The Media Monitoring Project has also published two comprehensive literature reviews: *Suicide and the Media,* which examines whether representation of suicide in the media can influence others to suicide and the manner in which this influence may occur; and *Mental Health and Illness in the Media,* which explores how mental health and illness are represented in the media and the effect this may have on community attitudes.

All Mindframe Initiative resources are available free of charge and can be accessed through the Mindframe website http://www.mindframe-media.info/index.cfm. More detail on the Media Monitoring Project and its findings is provided at APPENDIX F.

School based mental health promotion – developing protective factors against mental illness and suicide at a population level

An effective way of promoting mental wellbeing to a large percentage of young people is through the school environment. The Australian Government funds the MindMatters and KidsMatter Primary initiatives, which aim to embed promotion, prevention and early intervention activities for mental health and well being in Australian schools.

MindMatters and KidsMatter, for secondary and primary schools respectively, have the goals of:

- enhancing the development of school environments where young people feel safe, valued, engaged and purposeful;
- developing the social and emotional skills required to meet life's challenges;
- helping school communities create a climate of positive mental health and wellbeing;
- developing strategies to enable a continuum of support for students with additional needs in relation to mental health and wellbeing; and
- enabling schools to better collaborate with families and the health sector.

In this way these initiatives build on the work schools are already doing to address the mental health of their students through national, state and territory and sector-based mental health initiatives and policies.

Both MindMatters and KidsMatter Primary align with the WHO Global School Health Initiative: Health Promoting Schools[29] which is a population health approach to school based programs.

MindMatters

MindMatters is the national mental health promotion, prevention and early intervention initiative for Australian secondary schools. It commenced in 2000 and is delivered by Principals Australia, which works directly with both government and non-government schools.

MindMatters provides hardcopy materials to every secondary school in Australia, a website, and delivery of professional development to teachers and other school personnel on an opt-in basis. MindMatters resources include background information for schools, planning tools, activities for classroom use on various mental health topics and links to a list of programs and web sites that contain reliable information and details of health support networks.

Initiatives such as MindMatters which promote resilience and early help seeking continue to be a key population health approach to preventing youth suicide.

Evaluations have shown 70% of Australian secondary schools have used MindMatters[30]. In addition, over 75% of schools surveyed had made changes in the way they provide for student mental health and wellbeing including in their policy, practices and welfare processes[30].

These evaluations found a number of student changes and or patterns of improvement were reported in MindMatters schools, most of which are key elements to improving mental health outcomes for students. These included: an increased sense of attachment to school; greater connectedness and support between students; reduced bullying and less 'acting out"; a decrease in the number of days in which alcohol was consumed; a decrease in the number of days in which marijuana was used; and a better understanding of mental health concepts and issues amongst students.

KidsMatter Primary

KidsMatter Primary is the national primary school mental health promotion, prevention and early intervention initiative for Australian primary schools, both government and non-government. DOHA developed KidsMatter Primary in collaboration with beyondblue, the Australian Psychological Society and Principals Australia.

KidsMatter Primary concentrates on four key areas aimed at improving student wellbeing and lessening the likelihood of children developing mental health difficulties:

- a positive school community;
- social and emotional learning for students;
- parenting support and education; and
- early intervention for students experiencing mental health problems.

KidsMatter Primary requires a planned and coordinated approach throughout the school, involving all staff and engaging parents and the school community at various stages. To begin with each school establishes a leadership team to plan and oversee the implementation of KidsMatter Primary. These teams are supported by people with mental health expertise who provide training for teachers so they can implement activities that support the four key areas.

Students are taught 'resilience skills', helping them to cope with change, make and keep friends and manage their emotions. Teachers and parents are given information on child development and how to respond to a child who is experiencing mental health difficulties. A range of resources is available, including a website.

During 2007-08, KidsMatter Primary was piloted in 101 schools nationally in metropolitan, rural and remote locations and in government, Catholic and independent systems in all States and Territories. Partnerships are currently being sought with school systems in every state and territory to increase the number of schools that can implement KidsMatter Primary. It is expected that a further 300 schools will be involved by the end of the 2010 school year.

An evaluation of the KidsMatter Primary pilot by Flinders University, funded by beyondblue, showed the effectiveness of the pilot and is expected to be released in November 2009. Early results from the evaluation showed unexpectedly good results in measured mental health outcomes. It found KidsMatter Primary had a positive impact on children, school staff, parents and carers. This included improvements to student optimism and coping skills, and reduced mental health difficulties such as emotional symptoms, hyperactivity, conduct and peer problems. The ability of teachers and parents to help students with their difficulties was also improved.

Access to Means

It is well recognised that reduction of access to lethal means for dying by suicide is a key, evidence based method for reducing the number of deaths by suicide[11,12,17]. Examples of reduction of access to means include:

- firearm control legislation to reduce deaths by firearms;
- detoxification of domestic gas supply;
- replacement of pharmaceuticals with a narrow therapeutic range with pharmaceuticals of similar efficacy and a broader therapeutic range (ie the phasing out of barbiturates and replacement with benzodiazepines);
- packaging of analgesics;
- changes to automobile exhaust gas toxicity following the introduction of catalytic converters; and
- provision of barriers at jumping sites.

DOHA has made some investments in limiting access to means as a universal suicide prevention intervention although most access to means interventions lie outside the area of influence for health departments. DOHA worked over many years with the automotive industry investigating ways to reduce the possibility of automobile exhaust being used as a means of suicide. Possible access reduction mechanisms included engine cut off switches that were triggered by cabin exhaust fume concentration and exhaust pipe designs that resisted efforts to secure hosing. Ultimately these efforts were overtaken by the secondary effect of reduced fume toxicity by the transfer of most vehicles to catalytic converter technology intended to reduce environmentally harmful emissions.

More recently, ASPAC and DOHA have been examining the evidence behind restricting access to suicide 'hot spots' such as bridges or clifftops known to be frequently used suicide locations. While funding of physical infrastructure to reduce access is outside of the scope of the NSPP program funding, advice on reduction of access to means in this way is within the remit of the NSPS. Work is currently underway to provide guidelines for local government authorities and others with responsibility for infrastructure development on the evidence and best practice methods behind reduction of deaths by jumping through restricting access.

Community based funding for universal suicide prevention programs

Most universal suicide prevention activity funded under the NSPP to date has been nationally available. However, there are instances where local projects have taken a universal approach to suicide prevention at a whole of community level, for example:

The **Community Response to Eliminating Suicide (CORES)** project is funded to operate in northern Tasmania and aims to provide community capacity building centred on the prevention and intervention of suicide. Local community members are trained to be trainers and then deliver the program to their own community. The program focuses on helping community members to be able to identify people who might be suicidal and training them to positively engage in discussions to promote help seeking.

The **Wesley Mission Lifeforce Community Networks** project focuses on supporting improved suicide prevention activities through a collaborative and strategic community approach. The establishment of each network promotes inter-agency cooperation and raises community awareness of suicide risk and protective factors and mental health issues. This both directly and indirectly benefits those individuals at risk of suicide and those affected by suicide through, for example, improved referral systems and resource knowledge.

7. SELECTIVE AND INDICATED INTERVENTIONS FOR POPULATION GROUPS AT HIGHER RISK OF SUICIDALITY

- *Population groups, communities and individuals at higher risk of suicide need selective and indicated interventions to best target the specific risk factors that place them at elevated risk.*
- *Current population groups that are specifically targeted under the NSPS and NSPP include:*
  - *Aboriginal people and Torres Strait Islanders;*
  - *people living in rural and remote Australia;*
  - *people who are experiencing a mental illness and people who have previously attempted suicide or self harm;*
  - *young people;*
  - *people bereaved by suicide; and,*
  - *men.*

Universal suicide prevention activities are only one component of successful suicide prevention programs. They need to operate alongside selective and indicated interventions that support population groups, communities and individuals at higher risk of dying by suicide.

The NSPS Action Framework agreed by DOHA and ASPAC and approved by the Minister for Health and Ageing identifies a number of population groups at higher risk of suicide that should be the focus of selective and indicated interventions under the NSPP. Work is well established in some areas and requires further progress in others.

Selective Interventions

Selective interventions aim to work with groups and comminties who are identified as being at higher risk of suicide due to a clustering of risk factors, in order to build resilience, strength and capacity.

Table 11 summarises the projects funded under the NSPP which target specific groups at higher risk of suicide, and expenditure for these groups of projects during 2008-09.

Table 11: Summary of 2008-09 NSPP Expenditure for Groups at Higher Risk of Suicide

Population Group	Number of Projects	Expenditure GST Excl
Aboriginal & Torres Strait Islander Peoples	16	3,582,117
Rural & Remote	11	1,872,236
People with a mental Illness, previously attempted suicide or self harm	33	2,963,959
Young people	25	4,488,035
Bereaved by suicide	12	3,470,463
Men	9	2,265,680

	106	18,642,490
Number of projects and expenditure counted in more than one category	15	3,417,065
Total number of projects and expenditure for groups at higher risk	**91**	**15,225,425**

NOTE: Some double counting occurs for some categories when a project targets more than one population group. For example, a project may target men in rural and remote areas, an Indigenous project may target indigenous men or young people etc.

This section outlines some of the things we know about suicide in these groups of people at higher risk of suicide, as well as examples of projects that are in place to provide selective and indicated suicide prevention interventions to them. Details of the goals and outcomes of all the projects used as examples in this section can be found at APPENDIX C.

To date, the majority of selective and indicated interventions that have been funded under the NSPP have been community based projects. However, the section in this section that discusses interventions for people living with a mental illness and people who have previously attempted suicide describes projects that have been piloted widely across the country and may be able to be made available more widely after evaluation. In addition, most recent investment in support for people bereaved by suicide, while selective, has involved the replication of the StandBy Suicide Bereavement response model to increasing numbers of sites nationally.

Aboriginal people and Torres Strait Islanders

Suicide in Aboriginal and Torres Strait Islander Communities

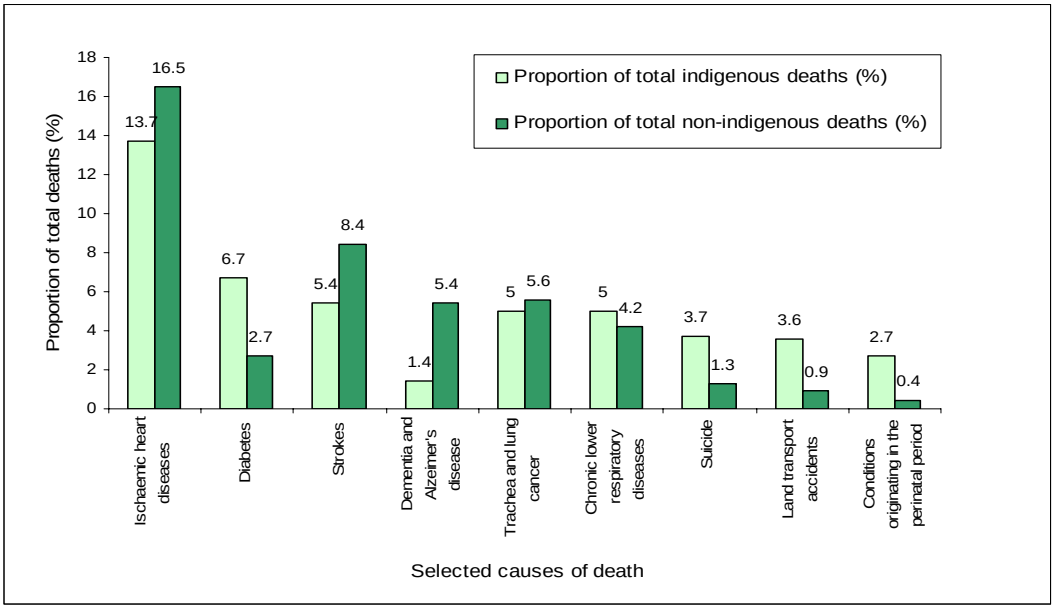
In 2007, suicide was the sixth leading cause of death among Indigenous Australians, with 3.7% of all deaths in Indigenous Australians being due to suicide (Table 9). The rate of suicide in the Indigenous population is almost three times greater than that of the non-Indigenous population (3.7% compared to 1.3%, Figure 10).

Table 12: Leading causes of death among Indigenous Australians by sex, 2007

Leading cause of death	**Male**	**Female**	**Persons**	Ranking
All causes	**1324**	**1097**	**2421**	**. .**
Ischaemic heart diseases (I20-I25)	204	127	331	1
Diabetes (E10-E14)	73	88	161	2
Strokes (I60–I69)	58	72	130	3
Trachea and lung cancer (C33-C34)	72	50	122	4
Chronic lower respiratory diseases (J40-J47)	59	62	121	5
Suicide (X60-X84)(e)	72	17	89	6
Land transport accidents(V01-V89)(f)	64	23	87	7
Cirrhosis and other diseases of liver (K70-K76)	43	42	85	8
Conditions originating in the perinatal period (P00-P96)	37	29	66	9
Diseases of the kidney and urinary system (N00-N39)	30	30	60	10

Source: Australian Bureau of Statistics[1]

Figure 12: Causes of death as a proportion of total deaths by Indigenous status, 2007



Source: Australian Bureau of Statistics[1]

While the ABS has noted that it is considered likely that most deaths of Indigenous Australians are registered, an unknown proportion of these deaths are not identified as Indigenous in the death registration process. In some cases this information is not sought or recorded for fear of offence or because Indigenous status is assumed based on appearance or other factors. It is also dependent upon whether the person is correctly identified as Indigenous by the family member or friend.

Current NSPP Projects targeting Aboriginal people and Torres Strait Islanders

Death by suicide for Aboriginal people and Torres Strait Islanders occurs in the context of multiple disadvantages that they face.
Some of the most successful suicide prevention activities in Aboriginal and Torres Strait Islander communities positively focus on the strengths of these communities, particularly the way that connection with culture can foster self-efficacy, respect and resilience.

DOHA recognises the need to gain advice on suicide prevention and mental health issues in Aboriginal and Torres Strait Islander communities from representatives of those communities who also hold expertise in mental health and suicide prevention. For this reason, the Indigenous Strategies Working Group (ISWG) provides advice to DOHA and to the Minister for Health and Ageing through ASPAC on the concerns of Aboriginal people and Torres Strait Islanders as they relate to mental health and suicide prevention policy and program development.

There are many individual projects that seek to work with Aboriginal and Torres Strait Islander communities to build resilience, strength and capacity. Examples include the **Koori Kids Wellbeing Project** that aims to improve the emotional and social wellbeing of Aboriginal children attending local primary schools in the Shoalhaven region of NSW. This project combines whole school approaches, but also incorporates counselling and psychological support for children with existing emotional and behavioural problems and parenting programs.

In Mildura, the local **Mildura Aboriginal Corporation** operates the **Hope, Opportunity, Purpose, Education and Employment (HOPE)** project, which provides psychological and coordination services to young Aboriginal and Torres Strait Islander students at risk of suicide and self harm, provides links to primary care and helps connect participants to positive lifestyle activities in art, culture and sport.

On Cape York, the **Queensland Police Citizens Youth Club** operates the **Something Better** project, which provides suicide prevention training local police and health personnel as well as providing community engagement activities to support local young people in the communities of in the communities of Mapoon, Lockhart River, Coen, Hope Vale, Wujal Wujal, Kowanyama and Napranum.

People living in rural and remote Australia

Suicide in rural and remote Australia

The risk of suicide increases with social isolation, including geographic isolation. In an analysis of Queensland Suicide Register* (QSR) data, the National Centre for Excellence in Suicide Prevention (NCESP) estimated that people living in regional Queensland had a 1.24 times relative risk of dying by suicide compared to people living in metropolitan and remote areas. People living in remote Queensland had a 1.99 times relative risk of dying by suicide compared to people living in metropolitan and regional areas[16].

This finding correlates with the findings of the 2007 AIHW report on rural, regional and remote health, which found that rates of death by suicide in regional Australia were about 20-30% higher than in major metropolitan areas (25-40% higher for males). In remote and very remote Australia, male rates of death by suicide were observed to be 1.7 and 2.6 times higher respectively[3].

ABS *Causes of Deaths, 2007* data for suicide is not available disaggregated by remoteness at this point in time. However, information has been produced by the NCIS on deaths in 2006. This shows that the deaths by suicide were highly associated with remoteness, with the rates significantly higher in Remote and Very Remote Areas (20.7 and 21.8 deaths per 100,000 population respectively).

Table 13: Suicide death rates by Remoteness Area, 2006

Remoteness Area	Suicide deaths per 100,000 population
Major cities	9.5
Inner regional	10.0
Outer regional	12.8
Remote	20.7
Very Remote	21.8

Note: Based on of usual residence of deceased.
Source: National Coroners Information System, unpublished.

* The Queensland Suicide Register (QSR) is a database of suicide mortality data managed since 1990 by the Australian Institute for Suicide Research and Prevention (AISRAP) and funded by Queensland Health. The database gathers information on deaths by suicide of all residents of Queensland, including data obtained from police reports, post-mortem and toxicology reports. Since 1994, psychological autopsy questionnaires have also been used. This information is predominantly provided by the Queensland Office of the State Coroner and cross-checked with the data available on the National Coroners Information System. Causes of death are then scrutinised in the QSR following the Suicide Classification Flow Chart, developed by the AISRAP, and categorised into: Beyond Reasonable Doubt, Probable, or Possible.

3 Stafford J, Sindicich N & Burns L (2009) *Australian Drug Trends 2008: findings from the Illicit Drug Reporting System (IDRS)*. Australian Drug Trends Series No. 19. NDARC: Sydney.

Current NSPP Projects targeting rural and remote Australia

Suicide prevention in rural and remote Australia needs to recognise the cultural and geographic uniqueness of communities outside the major metropolitan areas including the significant impact of climate events like drought or bushfire and the effects of geographical remoteness on self reliance and help seeking.

Many NSPP funded projects in rural and remote Australia focus on community capacity building and gatekeeper training, which helps maximise use of scarce community resources. For example, the **Farm-link** project run by the **Centre for Rural and Remote Mental Health** in country NSW helps to improve access to mental health services for NSW farming communities by developing links between health and community services and the agricultural sector. This includes the provision of Mental Health First Aid training to frontline agricultural sector workers.

In the Burdekin in North Queensland, the **Burdekin Community Association** provides the **Suicide Prevention and Mental Health Support Program** offering community based education for mental health, suicide prevention and alcohol and drug abuse. This includes suicide intervention training for community members, engagement with schools and youth groups and individual client support.

Access to mental health services is often difficult in rural and remote areas of the country, which can be significant in terms of suicide prevention given the recognised protective effect of access to appropriate mental health treatment. From 2006-07 to 2012-13 under the COAG National Action Plan on Mental Health, the Mental Health Services in Rural and Remote Areas (MHSRRA) Program will fund non-government organisations up to $91 million for the delivery of mental health services by appropriately trained mental health care workers in communities that would otherwise have little or no access to mental health services.

From 2010, workers employed under the MHSRRA program will have access to specially adapted suicide prevention training that has been developed by the Australian Psychological Society. This training will further enhance the capacity of primary care workers in rural and remote Australia to work with clients who are suicidal.

Young people

Suicide in Young People

A relatively small proportion of the total population aged 15-24 years die each year (1,194 or 0.1% of males and 0.02% females in 2007). However, unlike other age groups, most young people die from preventable causes and suicide is the leading underlying cause of death, accounting for approximately one-fifth of all deaths in this age group (Table 14).

Table 14: Leading underlying causes of death among 15-24 year olds, 2007

Leading underlying cause of death	Persons	Ranking
Intentional self-harm (X60-X84)	245	1
Car occupant injured in transport accident (V40-V49)	195	2
Motorcycle rider injured in transport accident (V20-V29)	44	3
Malignant neoplasms of lymphoid, haematopoietic and related tissue (C81-C96)	41	4
Accidental poisoning by and exposure to noxious substances (X40-X49)	40	5
Pedestrian injured in transport accident (V01-V09)	26	6
Assault (X85-Y09)	26	7
Other forms of heart disease (I30-I52)	24	8
Accidental exposure to other and unspecified factors (X58-X59)	23	9
Falls (W00-W19)	20	10

Source: Australian Bureau of Statistics[1]

In 2007, 22% of deaths among young males aged 15-24 and 17% of deaths among young females aged 15-24 were due to suicide (Table 15).

Table 15: Proportions of young people (15-24 years) dying and dying due to suicide, 2007

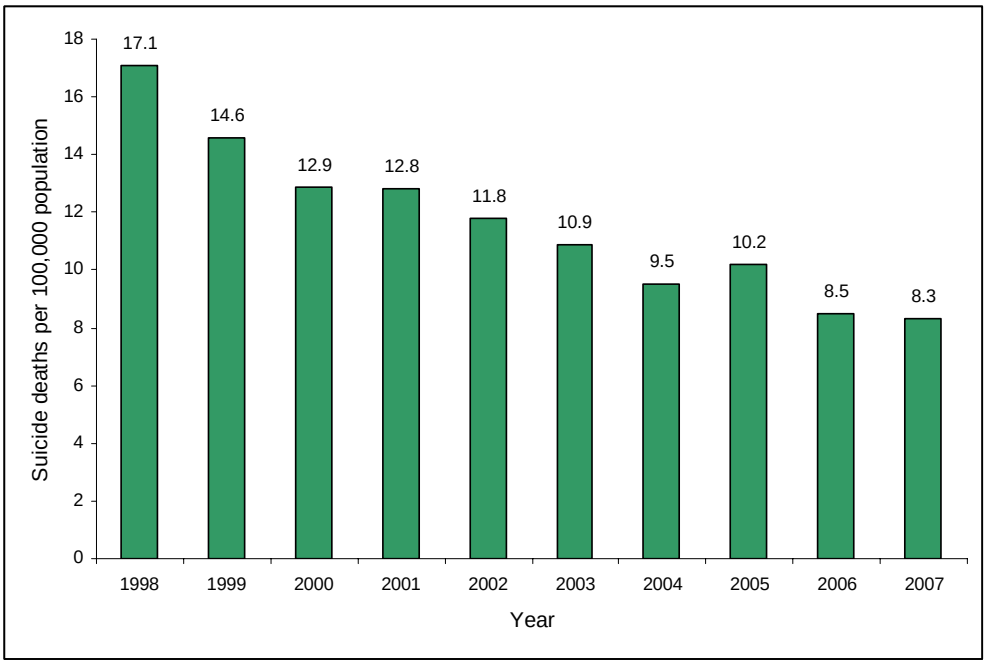
		1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
Proportion of 15-24 year olds dying (%)	Male	0.10	0.11	0.09	0.08	0.08	0.07	0.07	0.07	0.1	0.1
	Female	0.04	0.04	0.04	0.03	0.03	0.03	0.03	0.02	0.03	0.02
Proportion of all youth deaths due to suicide (%)	Male	26.5	22.8	21.6	24.2	25.2	24.0	20.7	24.7	19.7	22.0
	Female	16.6	14.9	15.8	16.6	14.8	12.3	16.8	16.4	13.3	17.0

Source: Australian Bureau of Statistics[1]

Source: Australian Bureau of Statistics[1]

In 2007, according to ABS data, there were 96 young people aged 15-19 years (69 males and 27 females) and 149 young people aged 20-24 years (118 males and 31 females) who died through suicide. This is equivalent to a rate of 8.3 deaths per 100,000 population. This is considerably less than in 1998, when official ABS data reported a total of 364 young people who suicided (17.1 deaths per 100,000 population, Figure 14).

Figure 13: Suicide deaths per 100,000 population among 15-24 year olds, 1998-2007



Source: Australian Bureau of Statistics[1]

Data is not reported by the ABS for people under 15 years old due to both the very small numbers each year and related sensitivities. The ABS in 2007 reported, however, that an average of 10.1 suicide deaths per year were reported over the 1998-2007 period. The highest number was registered in 1999 (17) and the lowest in 2006 (7), with around twice as many deaths by boys than girls.

The reduction in the burden of death by suicide in young people has not been uniform across all groups of young people. For example, recent articles have analysed the decline in young male suicide in Australia and the apparent disentanglement of young male suicide rates from young male unemployment rates[15], while other analyses have demonstrated that the reduction in suicide rates is not apparent in low socioeconomic status males aged 20-34 years[18]. Age specific suicide rates for Aboriginal and Torres Strait Islander males aged 0-24 years and 25-34 years remain three and four times the corresponding age-specific rates for non-Indigenous males respectively[2].

Current NSPP Projects targeting Young People

Youth-based suicide prevention projects funded through the NSPP tend to centre on building resilience and developing coping strategies and support networks for young people to increase the number of protective factors for suicide amongst vulnerable youth.

A balance is achieved between projects targeting the broader youth population and projects which focus on groups at increased risk of suicide, such as Indigenous youth, youth from refugee backgrounds and youth who identify as Lesbian, Gay, Bisexual and Transgender (LGBT).

The **Peer Support Program** is a national peer led program funded under the NSPP which fosters the mental, physical and social wellbeing of young people and their community by supporting positive cultural change within schools. The program is integrated into curricula in primary and secondary schools across Australia, and is aligned with the Kidsmatter Primary and Mindmatters programs.

A project which focuses on Indigenous youth is the **Yiriman Project** coordinated by the **Kimberley Law and Aboriginal Cultural Centre** in Western Australia. The project runs youth activities with support from senior cultural men and has established links with local agencies such as cultural activities and camps that build strong relationships, self identity and confidence in young people. Further, the **Something Better** project funded through the **Queensland Police-Citizens Youth Welfare Association** aims to assist and support young indigenous people in a number of Aboriginal communities in Queensland who are at risk of suicide through sporting activities outside of their community by a suitably trained and dedicated local person.

The **Expanding Horizons Project** run by the **Wesley Mission** is specifically targeted at engagement with LGBT young people, recently settled refugee young people and other young people identified as being at risk of suicide in the Gold Coast area of Beenleigh. The project aims to assist young people to develop respect and understanding of personal and social cultures around them through cross cultural awareness training.

Another project focusing on young people from refugee backgrounds is the **NEXUS Project** coordinated by the **Queensland Program of Assistance to Survivors of Torture.** The project aims to promote well being and resilience building in refugees aged 12-24 in Brisbane and Toowoomba by increasing three of the major protective factors for suicide: connectedness, locus of control and perceived academic performance. This is achieved through a series of school, employment and recreational activities, identification and counselling of high-risk individuals and training of school staff and community members.

Through 30 youth friendly shopfronts around Australia, the Australian Government funded **headspace** initiative provides access for youth to general practitioners and allied health professionals with skills and experience in alcohol and drug treatment and mental health, as well as access to other social and vocational support services. Although it is not funded through the NSPP, **headspace** is a complementary program that helps young people at risk of suicide to access appropriate and effective support for mental health problems, an important element in reducing risk factors for suicide.

People bereaved by suicide

Suicide in People Bereaved by Suicide

The NSPS explicitly recognises the need to provide specialist support to people who have been bereaved by suicide.

Individuals who are bereaved by suicide have indicated that a sense of guilt, shame, intense distress and efforts to understand the death can greatly complicate the grieving process. Complicated grief following bereavement by suicide places individuals at increased risk of developing or exacerbating physical and mental health conditions. In some cases, complicated grieving following a suicide can place a person at higher risk of suicide themselves.

Current NSPP Projects targeting People Bereaved by Suicide

Bereavement services are not only an essential part of providing support to individuals during the grieving process, but are also considered to be an important element of suicide prevention. Several projects are funded under the NSPP to provide effective support for those bereaved by suicide.

The **StandBy Bereavement Response Service** is an active 24-hour postvention service which provides support and assistance for those affected by suicide, as well as management of the bereavement circumstance. It coordinates local services, agencies and individuals to form a referral pathway to support to people bereaved by suicide. This involves the utilisation of local emergency and community support mechanisms such as police, ambulance, courts, health services and cultural and community groups.

A number of organisations are funded under the NSPP to provide the StandBy Service to regions throughout Australia including Cairns, Brisbane, Canberra and South Eastern NSW, the Sunshine coast, the Kimberley-Pilbara region in Western Australia and Tasmania.

The **Hope for Life** suicide bereavement support project run by the **Salvation Army** provides support for persons bereaved by suicide through a telephone help line, website, online and face to face suicide prevention gatekeeper training, and a resource kit for frontline Salvation Army staff dealing with people who are bereaved by suicide.

The **Active Response Bereavement Outreach Model** is a pro-active model of postvention which focuses on early engagement of those bereaved, including Indigenous people, within the Perth metropolitan area. Funded through the **Curtin University of Technology**, the service works in partnership with existing services including police, coronial counselling, medical and community services to enable people bereaved by suicide to be supported by a community network of peers and professionals.

Support for people bereaved by suicide within rural and metropolitan Victoria is available through the **Support after Suicide Service** coordinated by **Jesuit Social Services**. The service provides information and resources to the bereaved and the professionals supporting them, provides counselling and group work support, and aims to build the capacity of existing health, welfare and education services in metropolitan and rural Victoria to respond effectively and appropriately to people bereaved by suicide.

Men

Suicide in Men

Each year around four times more men than woman are likely to die by suicide (Table **16**).

Table 16: Males: Age-standardised suicide death rate per 100,000, 2007

	Males	Females	Sex ratio
1998	23.1	5.7	4.1
1999	21.3	5.1	4.2
2000	19.6	5.2	3.8
2001	20.1	5.3	3.8
2002	18.6	5.1	3.6
2003	17.6	4.8	3.7
2004	16.6	4.3	3.9
2005	16.4	4.3	3.8
2006	13.6	3.9	3.5
2007	13.9	4.0	3.5

Source: Australian Bureau of Statistics[1]

While suicide was ranked fifteenth in the leading underlying causes of death overall in 2007, for males was the tenth leading underlying cause (Table 17).

Table 17: Leading underlying causes of death among males, 2007

Leading cause of death	Males	Ranking
Ischaemic heart diseases (I20-I25)	12,119	1
Trachea and lung cancer (C33-C34)	4,715	2
Strokes (I60–I69)	4,516	3
Chronic lower respiratory diseases (J40-J47)	3,169	4
Prostate cancer (C61)	2,938	5
Dementia and Alzheimer's Disease (F01-F03, G30)	2,415	6
Colon and rectum cancer (C18-C21)	2,221	7
Blood and lymph cancer (including leukaemia) (C81-C96)	2,067	8
Diabetes (E10-E14)	1,923	9
Suicide (X60-X84)	1,453	10

Source: Australian Bureau of Statistics[1]

The vulnerability of separated and divorced men, particularly those involved in custody disputes and negotiated settlements, has been raised as a key factor in the increased numbers of deaths seen in males. Analysis of this issue is very difficult with the available national data, in which those who are separated, divorced and widowed are bundled together.

Data from the 2007 National Survey of Mental Health and Wellbeing[21] showed that, while the prevalence of suicidal ideation was over five times higher in people who were separated, divorced or widowed (5.6%) and suicide plans three times higher (0.9%) compared to those who were married or in de-facto relationships (1.1% for suicide ideation and 0.3% for suicide plans), suicide attempts were highest among those who had never married (0.7% compared to 0.1% for those separated, divorced or widowed).

Current NSPP Projects targeting Men

A number of projects are funded under the NSPP which are aimed specifically at providing support and reducing suicidal behaviour amongst men, given the high proportion of male suicides, and the specific characteristics of help-seeking behaviour that are often attributed to men.

This includes the **OZHelp Project** and the **Victorian Building and Construction Industry Life Care Skills** Project which work with building and construction industry apprentices and young workers (who are predominantly male), to reduce the prevalence of suicide risk within the industry. This is achieved through increasing workers' access to resources and support, and the development of referral networks and social capacity building skills.

The **Community Connections** project, the **Older Men's Network** assists men over 50 in and around Toowoomba, Queensland, who are on their own or are experiencing high degrees of loneliness, by developing a social network to help them with coping strategies and motivational activities in their own community.

Men both young and old within the Mt Druitt area of NSW who have attempted suicide or are bereaved by suicide are able to gain emotional support through the **Building Men's Resilience and Community Capacity in Outer Western Sydney** project run by the **Men's Health Information and Resource Centre**. The project also provides access to appropriate mental health and practical information and referral services for men in the local community, with a particular focus on the local Indigenous community.

Indicated interventions

This category of activity under the NSPS targets individuals who are showing signs of suicidality, present symptoms that are strongly associated with suicide (eg depression or other forms of mental illness) or are in circumstances that place them at highest risk of suicide. This is a relatively new area of direct investment under the NSPS.

There is a clear intersection here between the focus of actions under the NSPS (including investment under the NSPP) and broader investment by all governments in mental health services and programs, particularly those targeting individuals in time of crisis and escalating symptoms. It is beyond the scope of this submission to detail the broad range of mental health services and programs which are of relevance to providing indicated interventions.

The Australian Government has recently funded projects which aim to support individuals who have attempted suicide or self harm through direct investment under the NSPP in an extension of the Access to Allied Psychological Services project. This project has been planned in consultation with state and territory governments, and requires their support and commitment to ensure that individuals who have presented to Accident and Emergency services following a suicide or self harm attempt are referred upon discharge for support to the ATAPS suicide prevention project, run through the local division of general practice.

People living with a mental illness and people who have previously attempted suicide or self harm

Suicide in people living with a mental illness and people who have previously attempted suicide or self harm

Not everyone who experiences suicidal behaviour has a mental illness. The impulsive nature of some suicidal behaviour means that mental illness is not always an underlying factor. However suicidality is significantly more common among people with mental illness, and their risk of suicide is much higher[21].

The NSPS and NSPP also aim to reduce suicidal *behaviour*, recognising that people who have attempted suicide are among those at greatest risk of suiciding.

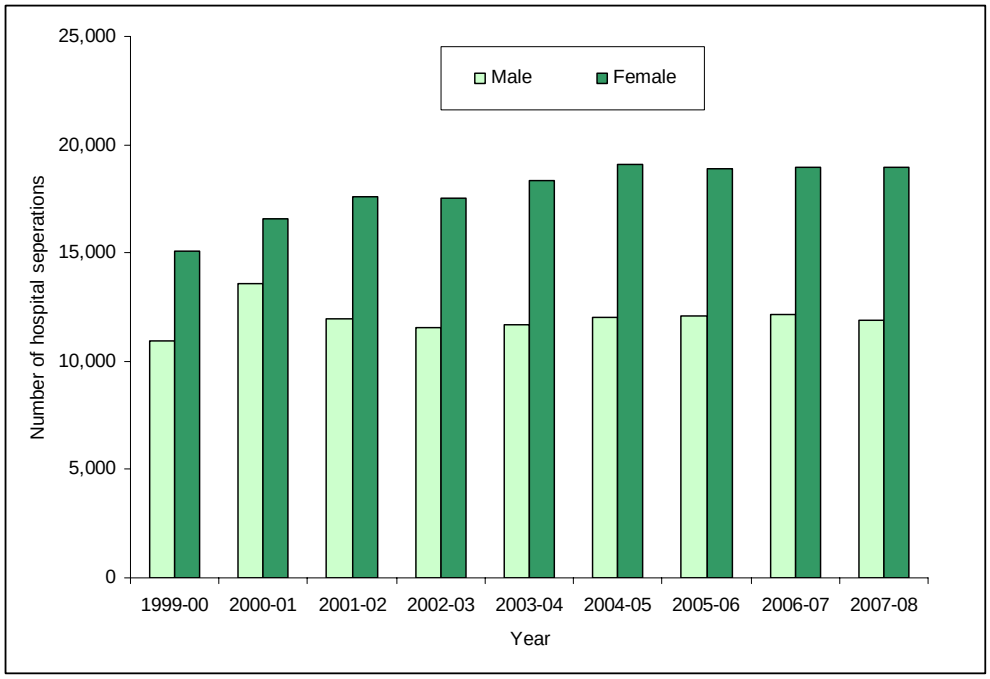
Data on admitted hospital patients shows around 30,000 admissions to Australian public hospitals each year for self-harm, with one-and-a-half times to twice as many admissions of females as admissions of males (Table 18, Figure 14 and Figure 15). In 2007, 11,883 males and 18,938 females were admitted.

Table 18: Hospital separations involving self-harm by sex and age, 1999-00 to 2007-08

Sex	Age group	2003-04	2004-05	2005-06	2006-07	2007-08
Males						
	0-14	150	169	160	132	117
	15–24	2,659	2,753	2,715	2,752	2,727
	25–34	3,387	3,314	3,203	3,138	2,976
	35–44	2,726	2,815	2,826	2,890	2,809
	45–54	1,488	1,659	1,744	1,791	1,818
	55–64	724	725	761	784	788
	65–74	289	296	329	320	335
	75–84	186	252	231	239	228
	85 and over	84	73	93	83	85
	Total[3]	*11,693*	*12,056*	*12,063*	*12,129*	*11,883*
Females						
	0-14	600	710	651	592	505
	15–24	5,615	6,123	5,864	5,823	5,720
	25–34	4,098	4,111	4,017	3,930	3,978
	35–44	3,973	3,925	3,950	4,157	4,230
	45–54	2,568	2,667	2,731	2,757	2,753
	55–64	867	923	1,015	972	1,056
	65–74	299	347	357	350	360
	75–84	247	228	220	272	256
	85 and over	90	61	88	100	80
	Total[3]	*18,357*	*19,095*	*18,893*	*18,953*	*18,938*
Persons[3]						
	0-14	750	879	811	724	622
	15–24	8,274	8,876	8,579	8,575	8,447
	25–34	7,485	7,425	7,222	7,068	6,955
	35–44	6,699	6,740	6,776	7,050	7,041
	45–54	4,056	4,326	4,475	4,548	4,571
	55–64	1,591	1,648	1,776	1,756	1,844
	65–74	588	643	686	670	695
	75–84	433	480	451	511	484
	85 and over	174	134	181	183	165
Total[3]		**30,050**	**31,151**	**30,958**	**31,085**	**30,824**

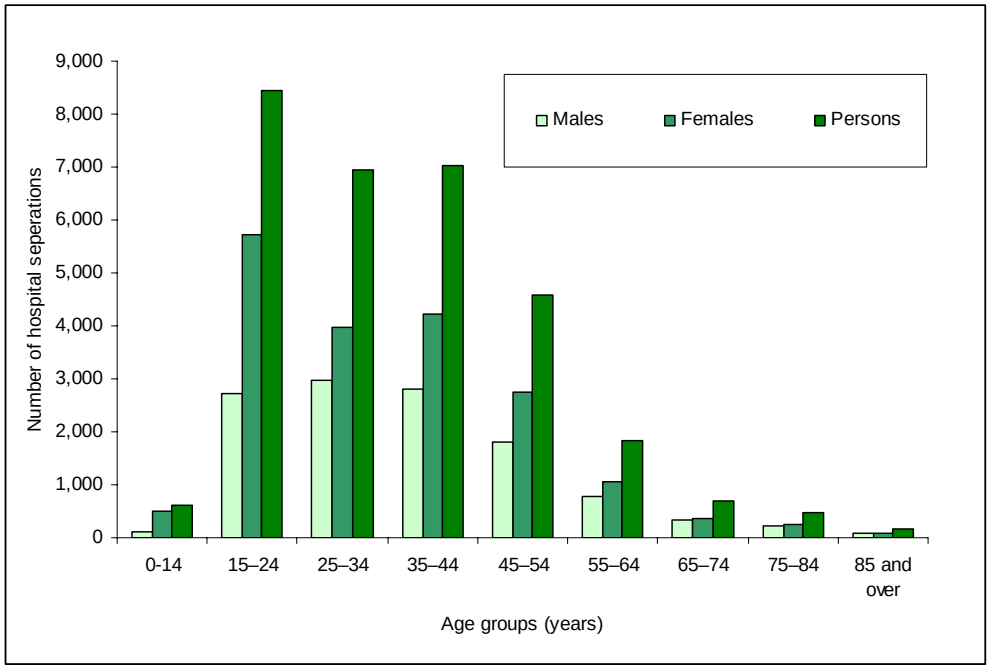
Note: Includes separations with an external cause code of intentional self-harm (ICD-10-AM codes X60–X84).
Source: National Hospital Morbidity Database, Department of Heath and Ageing, unpublished data.

Figure 14: Hospital separations involving self-harm, 1999-00 to 2007-08



Source: National Hospital Morbidity Database, Department of Heath and Ageing, unpublished data.

Figure 15: Number of hospital separations involving self-harm by age and sex, 2007-08



Source: National Hospital Morbidity Database, Department of Heath and Ageing, unpublished data.

Not all people who attempt suicide, however, are admitted to hospital. The 2007 National Survey of Mental Health and Wellbeing[21], a major epidemiological study representative of the Australian population, included a detailed module on suicidality.

This found that 13.3% of Australians aged 16-85 years have, at some point in their lives, experienced some form of suicide ideation, 4.0% had made a suicide plan and 3.3% had attempted suicide. This is equivalent to over 2.1 million Australians having thought about taking their own life, over 600,000 making a suicide plan and over 500,000 making a suicide attempt during their lifetime (Table 19).

Table 19: Prevalence of lifetime and 12-month suicidality

	Lifetime prevalence (%)	12-month prevalence (%)
Suicidal ideation	13.3	2.3
Suicide plans	4.0	0.6
Suicide attempts	3.3	0.4
Any suicidality	13.3	2.4

Note: Any suicidality is lower as people may have reported more than one type of suicidality in the 12 months.
Source: 2007 National Survey of Mental Health and Wellbeing

In the 12 months prior to interview, 2.4% of the total population or just over 380,000 people reported some form of suicidality. Of these, 2.3% or around 370,000 people experienced suicidal ideation, 0.6% or 91,000 made suicide plans and 0.4% or 65,000 made a suicide attempt.

The 12-month prevalence of suicidal ideation was higher in females (2.7%) than in males (1.9%). Although there was not a statistically significant difference between the sexes for suicide plans and attempts, both behaviours were slightly higher in females.

For females, suicidality was highest in those aged 16-24 years (5.1%) and decreased significantly with increasing age, with the exception of females aged 25-34 years (Table 20). For males, suicidality varied relatively less across age groups. In males aged 25-34 years and 35-44 years the prevalence of suicidality was around 2.5% and across all other age groups it remained close to 1.5%.

Table 20: Prevalence of suicidality in the previous 12 months by age and sex

		16-24	25-34	35-44	45-54	55-64	65-74	75-85
Male	Suicidal ideation	1.7	2.3	2.4	1.5	1.7	n.p.	n.p.
	Suicide plans	0.5	0.5	0.6	0.2	n.p.	n.p.	n.p.
	Suicide attempts	0.5	0.8	n.p.	n.p.	n.p.	n.p.	n.p.
Female	Suicidal ideation	5.1	2.4	3.4	3.3	1.4	n.p.	n.p.
	Suicide plans	1.6	0.6	0.8	0.9	n.p.	n.p.	n.p.
	Suicide attempts	1.7	0.8	n.p.	n.p.	n.p.	n.p.	n.p.
Persons	Suicidal ideation	3.4	2.3	2.9	2.4	1.5	1.1	0.8
	Suicide plans	1.1	0.5	0.7	0.5	n.p.	0.3	n.p.
	Suicide attempts	1.1	0.8	0.2	0.2	n.p.	n.p.	n.p.

Source: Johnston, Pirkis & Burgess (2009) reporting 2007 National Survey of Mental Health and Wellbeing data

It is a common belief that all people who are suicidal are mentally ill at the time. 0.8% of those surveyed who reported suicidal behaviour in the preceding 12 month period were assessed as not having a mental disorder. The risk of suicidality and death by suicide are, however, significantly higher in people who experience mental illness. Suicidality in the previous 12 months was reported by 8.6% of people with a 12-month mental disorder – three and a half times higher than suicidality in the general population.

In terms of the relationship of suicidality and specific classes of mental disorders, the strongest association was between suicidality and affective disorders such as bipolar disorder and depression (Table 21). Suicidal ideation was around one half times higher for those with affective disorders than for those with substance use disorders and anxiety disorders (16.8% compared to 10.8% and 8.9% respectively). Suicide plans and attempts were two times higher for affective disorders than for substance use disorders, and even higher than in people with anxiety disorders.

Table 21: Prevalence of 12-month suicidality by 12-month mental disorder class

	Suicidal ideation (%)	Suicide plan (%)	Suicide attempt (%)	Any suicidality (%)
Affective disorders	16.8	6.0	4.3	17.4
Anxiety disorders	8.9	2.4	2.1	9.1
Substance use disorders	10.8	3.5	3.1	10.9
Any mental disorder	8.3	2.2	Np*	8.6

Note: Totals are lower than sum of disorders as people may have had more than one class of mental disorder.
*Np: Not available for publication.
Source: 2007 National Survey of Mental Health and Wellbeing

Nearly two thirds (64.0%) of people who reported suicidality in the previous 12-months experienced high or very high levels of psychological distress in the 30 days prior to interview (Table 22). Psychological distress was high to very high for 63.2% of people with suicidal ideation, 71.2% of people who made a suicide plan and 69.6% of those who attempted suicide.

Table 22: Proportion of people with each psychological distress (K10) level by type of suicidality

	Low (%)	Moderate (%)	High (%)	Very high (%)
Suicidal ideation	11.8	22.9	38.1	27.1
Suicide plan	10.1	18.7	34.9	36.3
Suicide attempt	Np*	Np*	44.7	24.9
Any suicidality	13.1	22.7	37.1	26.9

*np: Not available for publication, but included in totals where applicable.
Source: 2007 National Survey of Mental Health and Wellbeing

The survey found that just over half (58.6%) of people with any form of suicidality in the previous 12 months used health services for help with their mental health problems in the same period (Table 23).

Over two thirds (68.0%) of people who reported making a suicide plan used services in the past 12 months. This was a much higher level of service use than found in the general population (11.9%) and almost twice the service use found in people with 12-month mental disorders (34.9%).

Nearly three quarters (73.4%) of people who reported making a suicide attempt used services for mental health problems. However, one in four (26.6%) people who made a suicide attempt did not access any services for mental health problems.

Table 23: Service use by type of suicidality

	Service use (%)
Suicidal ideation	59.1
Suicide plans	68.0
Suicide attempts	73.4
Any suicidality	58.6

Note: Any suicidality is lower as people may have reported more than one type of suicidality
Source: 2007 National Survey of Mental Health and Wellbeing

In addition, people living with a mental illness are particularly vulnerable following discharge from an episode of inpatient psychiatric care. Studies have estimated that the rate of suicide in people with a mental illness following discharge from inpatient psychiatric treatment could be over 200 times the rate of death by suicide in the general population[6]. The elevated risk of suicide is highest immediately following discharge, with 12.8% of deaths by suicide after discharge occurring on the day of discharge, 28.4% in the week following discharge, 47.7% in the month following discharge and 80% within one year of the last episode of inpatient psychiatric treatment[6].

Australian Government support for people living with a mental illness

Significant Australian Government effort and investment in helping people with a mental illness manage their suicidality has been through improving access to appropriate mental health services and medication through primary care and through additional mental health support services and programs.

New pathways to care through Better Access to Psychiatrists, Psychologists & General Practitioners through the Medical Benefits Schedule Initiative (Better Access) and through programs such as the Access to Allied Psychological Services (ATAPS) program have enhanced the mental health services available to people with mental illness and significantly increased treated prevalence for common mental disorders. Expanded telephone based crisis support services through organisations such as Lifeline, Kids Helpline and Crisis Support Service has also offered a safety net of immediately available support.

In addition, important work has been done to increase the capacity of primary care clinicians to work with patients who are experiencing suicidality, most notably through the development and dissemination of the **SQUARE** (**S**uicide **QU**estions, **A**nswers and **RE**sources) resources developed by the South Australian Division of General Practice and Relationships Australia SA with joint funding from the NSPP and the South Australian Government. The material is freely available at www.square.org.au and includes educational material and a support package for training and systems change in suicide risk assessment, intervention and follow up.

More recently, additional training is being made available to allied health professionals working under the ATAPS program and the Mental Health Services in Rural and Remote Areas (MHSRRA) Initiative. More detail is provided below on these programs.

Current NSPP projects targeting people living with a mental illness or who have previously attempted suicide or self harm

Two important and innovative projects to support people living with a mental illness or who have previously attempted suicide have been funded under the NSPP: one that provides innovative ways to support people with a mental illness following discharge from an episode of inpatient psychiatric care; and the second to support people who have been discharged from hospital following a suicide attempt.

The **Consumer Activity Network** operates the **Community Connections** project in Sydney and provides peer support and practical assistance to mental health consumers in the community for the first 28 days following discharge from psychiatric inpatient units in Liverpool and Campbelltown. In addition, the service offers a national telephone peer support non-crisis line for mental health consumers. Recent evaluation of the project found that consumers were very positive about the support provided to them.

The **Access to Allied Psychological Services (ATAPS) Suicide Prevention Pilot** grew from an understanding that people who have attempted suicide are at very high risk of further attempts immediately afterwards, but that intensive support in a primary care or community setting could greatly help reduce this risk. The purpose of the project is to provide better support for people at high risk of suicide after presentation to an emergency department or general practitioner following a suicide attempt or self-harm. The project facilitates priority access to referral pathways to specialised allied psychological services for people who have self-harmed, attempted suicide or who have suicidal ideation.

Funding is being provided to 18 demonstration sites around Australia. Divisions of General Practice in these demonstration sites receive funding to engage allied health professionals to deliver more flexible and intensive services. The allied health professionals involved in the delivery of this project receive additional specialised training in providing clinical care to people who have attempted suicide and self-harm.

A dedicated telephone line supports both clients and allied health professionals involved in the pilot by ensuring that clients are contacted by an allied health professional within 24 hours when this is required outside of business hours, providing an after-hours call back service for clients at particularly high risk of suicide who have been referred to ATAPS through the pilot, and providing a crisis support service for clients.

Approximately $3.8m has been allocated between June 2008 and December 2009 to develop, establish and operate the pilot and associated support structures. A decision has recently been made to extend the pilot to June 2010. Between January 2009 and June 2009, 462 client referrals were made to the ATAPS Suicide Prevention Pilot and 2,321 sessions were delivered although uptake has been variable across pilot sites. Over 260 GPs across Australia have referred patients to the trial.

8. NATIONAL SUICIDE PREVENTION INFRASTRUCTURE AND RESEARCH INTO SUICIDE AND SUICIDE PREVENTION

National Infrastructure

To support the implementation of the NSPS, the Australian Government invests in several items of supporting infrastructure. This includes funding for the LIFE Communications project and funding for the National Centre of Excellence in Suicide Prevention.

LIFE Communications

The 2005 Urbis Keys Young evaluation of the NSPS recommended that more frequent and better communication about suicide prevention processes, activities, progress and outcomes should be provided to the sector to facilitate sharing of experiences and learnings. This recommendation was the basis for developing the LIFE Communications project, which aims to improve the effectiveness of suicide and self-harm prevention activities in Australia by providing access to the latest information and shared learnings from the NSPS in suicide prevention, intervention and postvention. In particular, the project aims to promote the Living is for Everyone (LIFE) Framework and accompanying suite of resources to stakeholders in order to better contribute to more effective suicide prevention activity.

The LIFE Communications website is at www.livingisforeveryone.com.au

National Centre of Excellence in Suicide Prevention

The National Centre of Excellence in Suicide Prevention (NCESP) builds upon the internationally recognised activities of the Australian Institute for Suicide Research and Prevention (AISRAP) at Griffith University. Funding has been provided for three years until 2011.

The purpose of the NCESP is to:

- provide advice on evidence-based best practice suicide prevention activity to inform the NSPP workplan, commencing with the Access to Allied Psychological Services (ATAPS) program, but also in relation to other activity, such as population health approaches to suicide prevention through school-based activity;
- offer direct support to agencies contracted by DOHA to undertake new and emerging suicide prevention activities, particularly where this pertains to selective interventions to individuals who have attempted suicide or self-harm;

- provide a quarterly critical literature review outlining recent advances and promising developments in research in suicide prevention, particularly where this can help to inform national activities;
- provide advice on improving approaches to evaluation of suicide prevention activities and on the development of evaluation frameworks for new projects, such as the ATAPS suicide prevention project and other identified areas of the NSPS workplans; and
- provide advice on the implications of existing suicide prevention data and on issues around the credibility of suicide data.

Research

Under the expanded funding available to the NSPP from 2006, the Australian Government committed to providing funding for national research and development to increase the understanding of suicide and how to prevent it. Previously the scope of the NSPP did not allow for funding of research projects.

WHO-START

The Australian Government has provided funding towards the WHO's Suicide Trends in At-Risk Territories (WHO-START) Study from March 2008 to May 2010 to investigate preventative interventions across various countries, cultures and population sub-groups within the Asia-Pacific region. It will provide an appraisal of the role of cultural factors in suicidal behaviours and will provide a context for the implementation of specific culturally sensitive prevention practices at local, regional and national levels.
The overall goal of this study is to reduce suicide in the 22 WHO Western Pacific Region nations and associate members, areas and territories through four phases:

1. Mortality and morbidity (suicide attempts/self-harm) from 22 nations in the region.
2. Treatment and aftercare of suicide attempters (Interventions study);
3. Psychological Autopsy – study of suicide victims (Trans-Cultural Comparison of Risk Factors for Suicide); and
4. Longitudinal evaluation of medically serious suicide attempters.

The ultimate goal of this study is to increase suicide awareness whilst developing suicide prevention practices and increase capacity building within the Western Pacific Region, which has higher suicide rates than the global average[25].

This large scale study will also provide significant insights into the cultural factors in suicidal behaviours not only in the Western Pacific Region, but in Australia and world-wide. Under the coordination of AISRAP, the project will create a network of researchers, clinicians and public health administrators. The increased awareness and sensitivity towards suicide phenomena will be able to generate innovative research, develop education and training and actively encourage regional and national suicide prevention strategies and evaluate their impact.

As a Collaborating Centre for the WHO, AISRAP is currently managing this project. The WHO-START study is also the only officially endorsed study of the International Association for Suicide Prevention (IASP).

Case Control Studies

The Australian Government has funded the University of Sydney since May 2007 to undertake three cases-control studies of suicide and attempted suicide in young adults in New South Wales that were commenced under a National Health and Medical Research Council (NHMRC) Project Grant.

The overall research project aims to:

- quantify individual risk factors in combination with socio-demographic factors as contributors to suicide and attempted suicide; and,
- establish relationships between suicide and attempted suicide risk factors as they occur as background to and precipitants of suicide events.

The three individual studies are:

1. completed suicide cases compared to suicide community controls via an informant report interview attained from a next-of-kin or significant other for both cases and controls;
2. attempted suicide cases (defined as those who attend health services for the incident) compared to attempted suicide community controls via a self-report interview; and
3. suicide cases compared to attempted suicide cases.

This case-control design is unique in that it controls respondent bias in the study by using first person accounts for attempted suicide and controls, and second person accounts for suicide and for controls. The research design will have sufficient numbers of cases and controls to investigate suicide in a multi-level framework combining individual and psychiatric risk factors with contextual geographic and socio-demographic factors. This study will be able to examine rural-urban differences in suicide risk.

The final findings of the study are expected to be provided to DOHA in early 2010.

Australian National Epidemiological Study of Self Injury (ANESSI)

This research project was conducted between June 2007 and June 2008 and the final report was received in September 2008. The final report[28] is available to the public through the LIFE website.

The aim of the project was to determine the prevalence and nature of deliberate self-injury among the Australian population. More specifically, it aimed to show how many Australians aged 10 years and above have ever injured themselves deliberately during their lifetime. The project also collated other information on people who self injure, including which methods of deliberate self injury are currently used and what has been used in the past, on-going mental health status of people who self injure including drug and alcohol use, and suicidality. A significant section of this research included determining the prevalence and nature of deliberate self-injury among Aboriginal people and Torres Strait Islanders and rural and remote populations.

The final report estimated the four week prevalence of self injury in the Australian population to be 1.1%, or an estimated 231,000 people based on a population of 21,000,000, with slightly higher levels in females (1.2%, n=74) than males (0.9%, n=55). For women, self injury peaked in the age group 18-24, and for males, self injury peaked in the age group 25-34. For lifetime prevalence, the overall prevalence of self injury was 8.1% (n=977), with a higher prevalence in females 8.9%, n=542) than males (7.3%, n=435).

The four most common methods of self injury were cutting, scratching, hitting the body or a part of the body on a hard surface, and punching or hitting oneself. Over half of those who reported self injury claimed to be motivated by a desire to manage their emotions, and over one quarter self injured to punish themself. These results further refute the idea that people self injure in order to get attention and manipulate others, although the self reporting nature of the survey is a limitation in this sense. The majority of respondents (83%) who self injured in the four weeks prior to the survey did not receive medical attention, most likely because their injuries were not of a severe nature.

NHMRC funded research

While the capacity for funding research directly through the NSPP is limited, there are other sources of funding available to support research into suicide prevention and related areas. Table 24 summarises funding between 2000-01 and 2008-09 provided by the NHMRC to research projects for suicide and suicide prevention, mental health research other than suicide and substance use over the period 2000-01 to 2006-07.

Table 24: NHMRC Funding provided to research projects for suicide and suicide prevention, mental health research other than suicide and substance use.

	2000-01	2001-02	2002-03	2003-04	2004-05	2005-06	2006-07
All mental health (no double counts)	$12,352,358	$17,896,566	$23,065,461	$24,648,887	$31,177,428	$36,418,324	$40,616,184
All mental health (excluding suicide and substance use)	$7,554,985	$11,347,831	$14,805,552	$16,154,407	$20,436,821	$23,966,870	$28,915,711
All suicide	$965,738	$611,932	$347,888	$359,000	$551,675	$632,763	$583,363
All substance use	$4,024,683	$5,996,181	$7,912,021	$8,318,480	$10,308,432	$11,877,191	$11,117,110
Total (including double counts)	$12,545,406	$17,955,944	$23,065,461	$24,831,887	$31,296,928	$36,476,824	$40,616,184
Overlap between suicide and substanse use dataset	$193,048	$59,378		$183,000	$119,500	$58,500	
Total (incl double counts) minus overlap btw suicide and subs use	$12,352,358	$17,896,566	$23,065,461	$24,648,887	$31,177,428	$36,418,324	$40,616,184
All mental health (excluding suicide)	$11,386,620	$17,284,634	$22,717,573	$24,289,887	$30,625,753	$35,785,561	$40,032,821

Source: NHMRC

9. NATIONAL SUICIDE PREVENTION STRATEGY AND PROGRAM – EVALUATION, EVOLUTION AND FUTURE CHALLENGES

Since the establishment of the National Youth Suicide Prevention Strategy in 1995, the Australian Government's investment in suicide prevention has evolved in response to evaluations, emerging evidence in suicide prevention, the views of the community and implementation challenges. This section examines some of these factors and the consequent changes to the NSPS and NSPP to improve and measure the effectiveness of strategies and funded interventions.

Evaluation of suicide prevention efforts is extremely important but also very challenging. Suicide, despite its high impact, remains a rare event in technical terms, and as such it is difficult to link activities targeting a particular local or high need population to a reduction in suicide numbers.

Furthermore, when funding is directed through small non-government organisations, it is difficult to impose resource intensive processes for collection of qualitative and quantitative data.

Projects which aim to establish more universal approaches to improving protective factors against suicide, such as connections, resilience, and information and help seeking, are accepted to be evidence based and effective approaches to prevention of suicide. They are, however particularly hard to measure and monitor unless intermediate indicators of effectiveness are used.

2005 Evaluation of the NSPS

Previous evaluations of the Australian Government's earlier suicide prevention program and its projects have helped to inform the shape of the current NSPS. In 2005 Urbis Keys and Young was engaged by DOHA to conduct the most recent major independent evaluation of the NSPS as a whole. The evaluation also looked at the appropriateness, effectiveness and efficiency of the NSPP. It examined final evaluations of a number of individual funded projects as well as an analysis of two "cluster evaluations" of community-based projects. The evaluation also took written submissions, conducted a literature review of Australian and overseas evidence of effective suicide prevention activity, and conducted interviews with a large number of recognised Australian experts.

The evaluation found that, "[t]he NSPS is widely supported and perceived as an appropriate and necessary strategy that addresses an ongoing community need"[23]. Further, the evaluation concluded that, "there has been a good level of collaboration between the NSPS and the National Mental Health Strategy in particular. There is potential for greater linkages with some key policy and program areas, for instance, the National Drug Strategy, the Better Outcomes in Mental Health Care Initiative, beyondblue: the national depression initiative, and the Emotional and Social Well Being Initiative" [23].

Following the Urbis Keys Young evaluation, journal articles by noted suicide prevention sector experts examined the progress of the NSPP to date and made similar recommendations for shifts in direction for the next phase of the program[10,20]. Robinson, McGorry, Harris et al. concluded that a greater focus on selective and indicated interventions, particularly for people who have experienced mental illness, should be adopted to maximise the effectiveness of suicide prevention activities[20].

In all, the 2005 Urbis Keys Young evaluation made 34 recommendations about ways to strengthen the NSPS, in six categories. Table 25 summarises these categories of recommendations and outlines measures taken since by DOHA to strengthen the NSPS and improve the focus and administration of the NSPP in line with the recommendations.

Table 25: Summary of Recommendations from 2005 Urbis Keys Young Evaluation of the NSPS and examples of DOHA Actions to implement recommendations

The evaluation recommended:	DOHA has:
Strategic direction The next phase of the NSPP should develop specific goals and objectives in an implementation plan and be more targeted and directed while still incorporating a range of approaches to support population level interventions.	• DOHA has collaborated with the Australian Suicide Prevention Advisory Council (ASPAC) to develop a shared Action Framework for 2009-11 that will guide both the departmental administration of the NSPS and NSPP and the provision of advice by ASPAC to the Australian Government. • The Action Framework places greater emphasis on groups at greater risk of suicide including: Aboriginal people and Torres Strait Islanders; people living with a mental illness; people who have previously attempted suicide or self harm; people living in rural and remote Australia; men; young people and people bereaved by suicide. • The Action Framework continues to recognise the importance of maintaining investment in universal suicide prevention efforts.
Governance The roles and functions of NSPS governance should be clarified and possibly streamlined. The effectiveness of the Advisory Board's role in providing strategic advice should be strengthened and the appropriateness of the Board's role in advising on project funding should be reconsidered.	• The previous governance arrangements under the NSPS, which involved a complex network of Commonwealth and state committees, were discontinued. • DOHA reviewed NSPS governance and recommended that the Minister establish the ASPAC. • ASPAC was established in 2008 to provide strategic advice to the Australian Government on suicide prevention through the Minister for Health and Ageing. • ASPAC does not have a role in advising on individual project funding, but has a role in advising the Minister on principles and strategies that DOHA should use to administer funding under the NSPS and NSPP.

The evaluation recommended:	DOHA has:
Communication Strategy More frequent and better communication about NSPS processes, activities, progress and outcomes should be provided	• DOHA established the Living is For Everyone (LIFE) Communications project in June 2007. • The project: provides stakeholders with access to the LIFE suite of resources, the latest information, activities and resources in suicide prevention; provides stakeholders with a vehicle to contribute their learnings and draw on each other's expertise; and facilitates clear and effective communication channels across suicide prevention stakeholders in Australia.
Evidence base The evidence base for suicide and its prevention should be enhanced through a national suicide prevention research agenda and trial promising models of intervention through demonstration projects.	• The Australian Government has funded the establishment and operations of the National Centre of Excellence in Suicide Prevention to provide evidence based advice on best practice of suicide prevention in Australia and overseas. Funding is committed for three years until 2011. • New models of indicated intervention are being trialled through the ATAPS Suicide Prevention Pilot, administered by DOHA, which provides intensive psychological support to people who have attempted suicide or self harm.
Evaluation framework A comprehensive evaluation framework should be developed for the next phase of the NSPS including a mechanism to review and incorporate all the findings of existing and new NSPS funded projects.	• A comprehensive evaluation framework has been developed and implemented for the NSPS for 2006-11. This includes formal data collection requirements for all projects funded under the NSPP. This data will inform the final evaluation. • Plans are underway for an evaluation of the current phase of activity to conclude in 2010-11. • In addition, all major projects are required to complete their own external evaluation. • The 2006-11 evaluation will incorporate all this data as well as existing sources of information such as the Ausinet Learnings Project.
Program management systems Strengthen program information systems for NSPS funded activities and develop standard guidelines on NSPS program reporting.	• All funded projects have been provided with data collection tools that are tuned to the type of suicide prevention activity they are performing. • DOHA operates under standard program management policies and procedures that govern funding and procurement in accordance with the *Financial Management Act* and Commonwealth Procurement Guidelines. A Program Managers' Toolkit provide assists departmental officers to develop, manage, administer

The evaluation recommended:	DOHA has:
	and evaluate programs.

Since the findings of the independent review of the NSPS in 2005, there has been an increasing focus on evaluation of individual projects under the NSPS.

Effectiveness of funding community based projects

The NSPS and NSPP have also undergone a period of review and revision in their approach to funding locally based projects. There has been a shift over the last three years away from funding short term projects through competitive funding rounds in favour of longer term funding for projects that target needs identified through planning with State and Territory governments.

Following the 2005 review, the current phase of the NSPP commenced with the 2006 announcement by COAG of the National Action Plan on Mental Health 2006-2011[6] and expansion of Australian Government funding for the NSPP. This period saw an initial, large-scale open funding round for community based suicide prevention projects. While this process saw many projects funded that have been very well received and made real contributions to the communities in which they operate, subsequent analysis has identified a number of limitations with this approach.

First, the open nature of the funding round tended to favour larger, more established organisations with the capacity and experience to develop robust submissions. However, this did not mean the submissions that best met the criteria of the funding round always provided the best range of selected and indicated interventions that would add value to the mix of local services in any given location.

Secondly, the open and competitive nature of the process did not always allow for planning in consultation with jurisdictions and the non-government sector to ensure that funding went where it was most needed.

Over the last two years, with the agreement of the Australian Government, DOHA has shifted the administration of NSPP funding from an open competitive process to a more targeted approach. This has been demonstrated through the community based projects funded under the ATAPS suicide demonstration program. Areas targeted through this demonstration program were identified based on a planning process conducted in consultation with state and territory mental health directors, and with Divisions of General Practice. Invitations to submit proposals were then targeted to those 20 areas which would most benefit from such a project.

Similarly the recent extension of suicide prevention community grants has been undertaken through a process which involved the assessment of project performance and continuing need in consultation with state and territory health departments.

Headley, Pirkis, Merner et al. noted that for community based grants robust evaluation, retention of staff and stability of funding were key factors that marked more successful NSPP funded community based projects[10]. These three factors are clearly interdependent, as well-evaluated projects are more likely to attract stable funding sources and thus be able to retain staff. The recent extension of community based projects for a further two years has facilitated stability of funding for a total period of five years. Using the mandatory evaluation requirements of the NSPP, it is anticipated that the evaluation material gleaned from these projects over the period will provide a valuable source of information to inform future activities.

NSPS and NSPP influence on broader mental health programs and initiatives

The evolution of the NSPS and NSPP have had significant and positive flow-on impacts, which have seen the creation and establishment of a range of new mental health programs over the years. Programs which had their foundation or genesis in projects which were previously funded under the NSPP or its previous iterations include:

- the Youth Mental Health initiative, including headspace, which grew out of an emerging realisation of the importance of promoting better awareness and help seeking by young people and of the need for early intervention. These concepts were embedded in the Youth Suicide Prevention Strategy;
- the Telephone Counselling and Web-Based Therapies program, which was built upon knowledge acquired through the NSPS of the importance of providing phone based emotional support to individuals experiencing psychosocial crisis, and through experience funding programs and non-government organisations such as Kids Helpline;
- the Early Intervention for Children, Parents and Young People measure. This drew from NSPS experiences, particularly through school based programs, of the importance of building protective factors, including resilience and connectedness, into the learning environments of young children; and
- the COAG Indigenous Mental Health Initiative introduced in 2006, which took an Indigenous frontline training resource developed with funding from the NSPP to promote better detection and support by Aboriginal Health Workers of Indigenous people with or at risk of mental health problems.

Learning from the recommendations of the 2005 NSPS evaluation, cross-program collaboration for primary care based mental health treatment and suicide prevention has been actively promoted, with the Better Outcomes in Mental Health Care Initiative and NSPP supporting the ATAPS Suicide Prevention Pilot (refer pp.62), and individuals at risk of suicide becoming a specific target group of the broader ATAPS program.

The NSPP has also promoted the availability of frontline training for primary health care providers in identifying and responding to individuals at risk of suicide. Training for allied health workers participating in the Mental Health Services in Rural and Remote Areas Initiative in responding to people at risk of suicide is an example of this.

Links with Australian Government funded drug and alcohol services have been pursued through the Improved Services for People with Mental Illness and Comorbid Drug and Alcohol Problems measure which was part of the COAG National Action Plan for Mental Health[6]. These links remain important and opportunities to strengthen them links will be considered in the development of the National Drug Strategy for the period 2010-15.

Current Evaluation Framework for the NSPS

Following the recommendations of the 2005 Urbis Keys Young evaluation, DOHA in 2006-07 developed the *Evaluation Framework for the National Suicide Prevention Strategy*.

The funding agreements made with organisations that were successful under the 2006 open funding round included robust project evaluation parameters as part of the COAG reporting process, including mandatory minimum data collection requirements that were tailored to the type of project and the scale of the project. Further, organisations were provided with standardised tools to assist with the collection of this data.

Evaluations and reviews of significant national projects funded under the NSPP are currently underway. Building upon previous evaluations of the MindMatters initiative, an efficiency review of that program is currently being finalised. As mentioned previously, an evaluation of the KidsMatter Primary schools program has recently been completed and has found the pilot program effective in terms of improving mental health and educational outcomes. This evaluation is currently being published.

The LIFE Communications Project, currently managed by Crisis Support Service, is also to be subject to an independent evaluation in 2009-10.

Within the parameters of the evaluation framework, DOHA will conduct an independent evaluation of the entire NSPS to coincide with the evaluation of the COAG National Action Plan on Mental Health in 2011. This will comprise a meta-evaluation of all the independent evaluations and activity data collected by individual projects.

What has Resulted from the Australian Government's Suicide Prevention Efforts

Over recent years Australian Government investment in suicide prevention has provided a sustainable national foundation upon which future NSPS activity can progress. Specifically this has:

- raised the understanding in Australia of the evidence base underpinning suicide prevention strategies at a universal, selected and indicated level;
- communicated this understanding through action areas and resources now available through the recently redeveloped form of the LIFE Framework resources;

- set in place sustainable infrastructure to inform our national activities, and to communicate new evidence from around the world through the National Centre of Excellence in Suicide Prevention, the LIFE Communications project and the Australian Suicide Prevention Advisory Council;
- worked with sectors such as the media to engage them in improving approaches to communicating key messages about mental illness and suicide prevention – and we have seen significant improvements of media reporting in these areas;
- established a number of universal population health approaches to mental health promotion and suicide prevention, particularly targeting children and young people, which are now well placed to further evolve to improve their focus on early intervention and younger age groups;
- implemented frontline training for teachers, journalists, TAFE teachers, family court workers, rural mental health providers and others to increase their ability to identify and respond to individuals at risk of mental illness or suicide;
- enabled local communities to implement strategies which address perceived risks to protect their particular populations within the context of the LIFE Framework – and have developed approaches to improving the planning, evaluation and sustainability of these actions;
- increased the availability of specialised support and resources to particular groups at highest risk of suicide – including people bereaved by suicide, Indigenous Australians and people in rural and remote areas;
- introduced new selective interventions for people who have attempted suicide to provide specialised mental health support to them in the period immediately after their attempt;
- embedded elements of suicide prevention, such as frontline training, early intervention, the promotion of help seeking and other protective factors, into newer mental health programs such as the Victorian bushfire mental health response, the Mental Health Services in Rural and Remote Services measure, and headspace;
- facilitated improved joint planning processes with state and territory governments based on the LIFE Framework document and culminating in the recent agreement by Health Ministers through the Fourth National Mental Health Plan, to align Commonwealth and state suicide prevention activities through a new agreed national framework under the NSPS.

Future challenges

In addition to the challenge of evaluating and improving suicide prevention efforts, there are a number of broad areas where more needs to be done at a national level to reduce the suicide risk within the population and within particular target groups.

Suicide among Aboriginal people and Torres Strait Islanders continues to be an area of great concern to all governments and to the community. Efforts to address Indigenous

suicide need to be holistic and consider the complex interplay of factors which result in loss of hope among indigenous people, particularly Indigenous youth. The recent Blank Page suicide prevention summit[31] in the Kimberley highlighted this interplay, and the importance of communication between services, and ongoing efforts to raise the capacity of communities to support their young people, and to identify young people needing additional social and emotional support.

Increasing efforts to raise understanding of suicide and to enhance the capacity of a broad range of professionals and community members to identify and support people who may be at risk of suicide is also a challenge. There have been many efforts to support this already through the NSPP – particularly frontline training which has targeted teachers, journalists and members of some occupations working with people at higher risk of suicide. This approach has also been fundamental to other programs, including the Australian Government's Victorian Bushfires Mental Health Support package and the Mental Health for Drought Impacted Communities measure, both of which included investment in raising the capacity of frontline professionals to respond to individuals at risk of mental illness or suicide. A range of sectors need to embrace suicide prevention efforts if broad based attempts to increase frontline training are to be realised.

A related challenge is the tension between the need for increased awareness and knowledge about suicidal behaviour and the need to maintain duty of care in the way suicide is reported, discussed and communicated to minimise risk to vulnerable individuals.

Future suicide prevention efforts will need to continue to balance sound, evidence-based investment of available resources in universal suicide prevention efforts and in more targeted and tangible activities which target people at high risk. This challenge is exacerbated by the difficulty in measuring the impact of universal interventions in reducing suicide prevention. However, conversely, the greatest long term benefits can potentially be achieved through maintaining investment in such programs.

Finally, continuing efforts to align Australian Government suicide prevention activity across the Commonwealth and with state and territory government investment in suicide prevention will continue to be both a priority and a challenge. If optimal investment is to be achieved in suicide prevention targeting the needs of people with mental illness, particularly those with serious illness who use the specialist mental health system funded and run by the states and territories, better coordinated and integrated service delivery and support services will need to be provided. New governance arrangements for implementing the Fourth National Mental Health Plan 2009-14[26] will facilitate this alignment, particularly in relation to implementation of actions directly related to suicide prevention. A related challenge is alignment of Australian Government suicide prevention activity with broader cross sectoral program activity. New terms of reference for an Interdepartmental Committee (IDC) on Mental Health include ongoing consideration of suicide prevention. The IDC will be used to facilitate cross agency liaison to improve integration of suicide prevention issues and needs into mainstream programs.

10. CONCLUSION

Suicide remains an issue of significant concern to governments, stakeholders and the community. Through the National Suicide Prevention Strategy and its previous iterations over the last 14 years the Australian Government has improved its understanding of ways in which to prevent suicide through an iterative, and continually evolving process. Increased investment by the Commonwealth in mental health programs and services has also increased the availability of services and support for individuals at highest risk of suicide. A number of these programs have been informed and strengthened by principles underpinning suicide prevention, including the importance of early intervention, of developing protective factors within the community and promoting cross-sectoral partnerships to improve mental health and social outcomes.

Over the last two years in particular there have been a number of new developments and investments designed to provide a sustainable national foundation upon which future NSPS activity can progress, including the establishment of new governance through the Australian Suicide Prevention Advisory Council, and the establishment of the National Centre of Excellence in Suicide Prevention. Actions to further align Australian Government and state/territory suicide prevention activity through building upon the LIFE Framework will provide leverage for improved pathways for individuals at risk of suicide and shared priorities, resources and actions, including in areas such as frontline training.

With the additional benefit of improved suicide data at a national level it is anticipated that the targeting, alignment, improvement and communication of suicide prevention efforts and actions by all governments will continue.

BIBLIOGRAPHY

1. Australian Bureau of Statistics. 2009. ABS 3303.0 Causes of Death, Australia, 2007. ABS: Canberra. http://www.abs.gov.au/ausstats/abs@.nsf/mf/3303.0
2. Australian Bureau of Statistics. 2008. ABS 4704.0 The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples. ABS: Canberra. http://www.ausstats.abs.gov.au/ausstats/subscriber.nsf/0/51B575E133A75C6DCA2574390014EDFE/$File/47040_2008.pdf
3. Australian Institute of Health and Welfare. 2007. Rural, regional and remote health: a study on mortality (2nd edition). AIHW: Canberra. http://www.aihw.gov.au/publications/phe/rrrh-som-2/rrrh-som-2.pdf
4. Blood, R. and Pirkis, J. 2001. Suicide and the Media: A Critical Review. Department of Health and Ageing: Canberra. http://www.mindframe-media.info/client_images/372860.pdf
5. Bollen, K. and Philips, D. 1982. "*Imitative suicides: A national study of the effects of television news stories*". American Sociological Review 47 (6) 802-809.
6. Council of Australian Governments (COAG). 2006. National Action Plan on Mental Health (2006-2011). COAG: Canberra. http://www.coag.gov.au/coag_meeting_outcomes/2006-07-14/docs/nap_mental_health.pdf
7. De Leo, D. and Evans, R. 2004. International Suicide Rates and Prevention Strategies. Hogrefe and Huber: Cambridge and Göttingen.
8. De Leo, D., Hawgood J., Ide, N., Andersen, K. & Klieve, H. 2008. Post-Discharge Care in Psychiatric Patients at High Risk of Suicide. A report to the Commonwealth of Australia. Australian Institute for Suicide Research and Prevention, Griffith University: Brisbane. http://www.livingisforeveryone.com.au/IgnitionSuite/uploads/docs/Post%20Discharge%20Care%20in%20Psychiatric%20Patients%20at%20High-Risk%20of%20Suicide%202008.pdf
9. Harrison, J., Pointer, S. and Elnour, A. 2009. A Review of Suicide Statistics in Australia. AIHW: Canberra. http://www.aihw.gov.au/publications/inj/injcat-121-10754/injcat-121-10754.pdf
10. Headley, A., Pirkis, J., Merner, B., VandenHuevel, A., Mitchell, P., Robinson, J., Parnham, J. and Burgess, P. 2006. "*A Review of 156 Local Projects Funded Under the National Suicide Prevention Strategy: Overview and lessons learned*". Australian e-Journal for the Advancement of Mental Health 5 (3) 1-15.
11. Living is for Everyone. 2007a. A Framework for Prevention of Suicide in Australia. Department of Health and Ageing: Canberra. http://www.livingisforeveryone.com.au/IgnitionSuite/uploads/docs/LIFE_framework-web.pdf
12. Living is for Everyone. 2007b. Research and Evidence in Suicide Prevention. Department of Health and Ageing: Canberra. http://www.livingisforeveryone.com.au/IgnitionSuite/uploads/docs/LIFE_research-web.pdf

13. McLean, J., Maxwell, M., Platt, S., Harris, F. and Jepson, R. 2008. Risk and Protective Factors for Suicide and Suicidal Behaviour: A literature review. Scottish Government Social Research: Edinburgh. http://www.scotland.gov.uk/Resource/Doc/251539/0073687.pdf

14. Martin, G. 2007. *"Success! The Australian National Youth Suicide Prevention Strategy (1995-2000) worked. But what exactly made the difference?"* Australian e-Journal for the Advancement of Mental Health 6 (3) 1-5.

15. Morrell, S., Page, A. and Taylor, R. 2006. *"The Decline in Australian Young Male Suicide"*. Social Science and Medicine 62 747-54.

16. National Centre for Excellence in Suicide Prevention. 2009. Suicide Risk in Different Subpopulations in Australia (Queensland). Unpublished report to the Department of Health and Ageing.

17. Mann, J., Apter, A., Bertolote, J., Beautrais, A., Currier, D., Haas, A., Hegerl, U., Lonnqvist, J., Malone, K., Marusic, A., Mehlum, L., Patton, G., Phillips, M., Rutz, W., Rihmer, Z., Schmidtke, A., Shaffer, D., Silverman, M., Takahashi, Y., Varnik, A., Wasserman, D., Yip, P. and Hendin, H. 2005. *"Suicide Prevention Strategies: A systematic review"*. Journal of the American Medical Association 294 (16) 2064-2074. http://jama.ama-assn.org/cgi/reprint/294/16/2064

18. Page, A., Morrell, S., Taylor, R., Carter, G. and Dudley, M. 2006. "Divergent Trends in Suicide by Socioeconomic Status in Australia". Social Psychiatry Psychiatric Epidemiology 41: 911–917.

19. Pirkis, J., Blood, W., Dare, A., Holland, K., Rankin, B., Williamson, M, Burgess, P., Jolley, D., Hogan, N. and Chandler, S. 2008. The Media Monitoring Project: Changes in media reporting of suicide and mental health and illness in Australia 2000-01 to 2006-07. Department of Health and Ageing: Canberra.

20. Robinson, J., McGorry, P., Harris, M., Pirkis, J., Burgess, P., Hickey, I. and Headley, A. 2006. "*Australia's National Suicide Prevention Strategy: The next chapter"*. Australian Health Review 30 (3) 271-6.

21. Slade, T., Johnston, A., Teesson, M., Whiteford, H., Pirkis, J. and Saw, S. 2009. The Mental Health of Australians 2: Report on the National Survey of Mental Health and Wellbeing. Department of Health and Ageing: Canberra. http://www.health.gov.au/internet/main/publishing.nsf/Content/46AB7A3FEF9664E4CA2575D2000A6D09/$File/mhaust2.pdf

22. SCRGSP (Steering Committee for the Review of Government Service Provision). 2009. Report on Government Services 2009. Productivity Commission: Canberra. http://www.pc.gov.au/gsp/reports/rogs/2009

23. Urbis Keys Young. 2006. Evaluation of the National Suicide Prevention Strategy – Summary Report. Department of Health and Ageing: Canberra. http://www.health.gov.au/internet/mentalhealth/publishing.nsf/Content/EAF3A9E255355D1FCA257307001B4C10/$File/Public%20Report%20-%20May%209.pdf

24. WHO. 2009. Suicide Prevention (Supre). http://www.who.int/mental_health/prevention/suicide/suicideprevent/en/

25. De Leo, D., Milner, A. and Xiangdong, W. 2009. "Suicidal Behaviour in the Western Pacific Region: Characteristics and trends". Suicide and Life Threatening Behaviour 39 (1) 72-81.

26. Australian Health Ministers' Conference. 2009. Fourth National Mental Health Plan - An agenda for collaborative government action in mental health 2009-2014. Commonwealth of Australia: Canberra. http://www.health.gov.au/internet/main/publishing.nsf/Content/360EB322114EC906CA2576700014A817/$File/plan09.pdf

27. WHO. 2008. Preventing Suicide: A Resource for Media Professionals. WHO: Geneva. http://www.who.int/mental_health/prevention/suicide/resource_media.pdf

28. Martin, G., Hazell, P., Harrison, J., and Taylor, A. 2008. Australian National Epidemiological Study of Self-Injury (ANESSI). The University of Queensland: Brisbane. http://www.livingisforeveryone.com.au/IgnitionSuite/uploads/docs/ANESSI%20Final%20Report.pdf

29. WHO. 1998. WHO's Global School Health Initiative: Health Promoting Schools. Geneva, Switzerland. http://www.who.int/school_youth_health/media/en/92.pdf

30. Ainley, J., Withers, G., Underwood, C., and Frigo, T. 2006. National Survey of Health and Well-being Promotion Policies and Practices in Secondary Schools. Australian Council for Educational Research.

31. Billard Aboriginal Community Blank Page Summit on Suicide 2009. www.blankpagesummit.com.au

32. Mitchell, P. 2000. Valuing Young Lives: Evaluation of the National Youth Suicide Prevention Strategy. Australian Institute of Family Studies: Melbourne.

APPENDIX A. Summary of key Department of Health and Ageing programs that support suicide prevention outcomes through social inclusion and improved access to mental health and general health services

Office of Aboriginal and Torres Strait Islander Health

Program Name	Description	Funding Amount (2008-09 GST excl.)	Goals
COAG Closing the Gap in Indigenous Health Outcomes: *Improving the Capacity of Workers in Indigenous Communities initiative*	The measure supports health practitioners including Aboriginal Health Workers, nurses, counsellors and other clinic staff to identify and address mental illness and associated substance use issues in Aboriginal and Torres Strait Islander communities recognise the early signs of mental illness and make referrals for treatment where appropriate.	$3.641m	The measure supports development and delivery of mental health training to front-line staff in Aboriginal and Torres Strait Islander Medical Services, substance use services and social and emotional wellbeing services. The measure also provides an additional ten mental health worker positions nationally, as well as development of resources and information to support health practitioners to assist Aboriginal and Torres Strait Islander people at risk of, or experiencing mental illness.

Social & Emotional Wellbeing Regional Centres	The Action Plan 2001 resulted in several Emotional and Social Wellbeing Regional Centres (SEWB RCs) being established around Australia. SEWB RCs were set up to provide training and support for Aboriginal mental health workers and specialist social and emotional wellbeing counsellors, including Bringing Them Home (BTH) and Link Up counsellors and caseworkers.	$5.760m	The Department funded 12 SEWB RCs nationally and were originally set up with the following four objectives: 1. Development of information systems to clarify the level of social and emotional wellbeing need in the region and inform the operations of the Regional Centre. 2. Provision of personal and professional support to the health workforce. 3. Development of curriculum and delivery of training in social and emotional wellbeing. 4. Development of appropriate cross-sector linkages and inter-agency cooperation. An independent review conducted by Urbis Keys Young (UKY) during 2006/2007 found that SEWB RCs were not performing all of their functions equally well. As per the recommendations from the UKY report, the program was reformed. As a result the DOHA is currently implementing new arrangements for the operation of the SEWB RCs, which will now be called Workforce Support Units to reflect their changed roles.
Bringing them Home and Link up services	This measure supports Bringing them Home counsellors and Link up services to benefit members of the Stolen Generations and their descendants, families and communities, affected by past governments removal policies and practices.	$3.2m	These measures provides counselling, family tracing and reunion services for members of the Stolen Generation and their descendants, families and communities.

Australian Nurse Family Partnership Program (ANFPP) – funded through *Health@Home Plus* - 2007-08 Budget	The ANFPP, a sustained home-visiting program for women pregnant with an Aboriginal or Torres Strait Islander child, focuses on providing assistance to mothers to help them: • Engage in good preventative health practices; • To improve their child's health and development; and • Develop a vision for their own future, including education and employment.	$7.072m	The ANFPP is currently being implemented in five sites with a further two sites to be identified in 2010. This program is based on the Nurse Family Partnership Program developed by Professor David Olds in the United States over the past 30 years. Longitudinal studies have found that the Nurse Family Partnership Program had significant outcomes around social inclusion, such as increased use of community services and increased maternal employment. Other significant outcomes for mothers and their children include; increased birth weight; reduced maternal smoking; reduced childhood injuries; reduced reports of child abuse and neglect; fewer subsequent pregnancies and increased intervals between births; and improved school readiness of children. It is hoped these can be replicated in Australia. ANFPP supports mothers, as required, to access other services providing support around issues of substance use, mental health and suicide.
New Directions: An Equal Start in Life for Indigenous Children – Mothers and Babies Services	New Directions Mothers and Babies Services is working collaboratively with Aboriginal Medical Services and State and Territory Governments to deliver comprehensive maternal and child health services for Indigenous people.	$7.552m	This program supports Indigenous mothers with increasing access to antenatal and postnatal care; providing standard information about baby care; practical advice and assistance with breastfeeding, nutrition and parenting; monitoring of developmental milestones, immunization status and infections; and health checks for Indigenous children before starting school. With regard to social inclusion outcomes, the Mothers and Babies Services may provide information and education for issues around substance use and the availability of other community services for mental health and suicide issues.

COAG Drug and Alcohol Treatment and Rehabilitation Services in Regional and Remote Indigenous Communities - 2006 and 2007 Measures	The Measures provide additional drug and alcohol treatment and rehabilitation services to regional and remote Indigenous communities across Australia, including new services and new service types.	$17.629m	These Measures support the delivery of holistic and culturally appropriate treatment of drug and alcohol issues working towards the ongoing recovery of individuals, families and communities. These Measures are focused on improving services available to regional and remote Indigenous communities. Although not specifically targeted at suicide prevention, a large proportion of individuals with substance use issues have co-existing mental health issues and services frequently deliver suitable programs and appropriate referral to mental health services and acute health services. Linkages have also been developed with the COAG Mental Health Measure at a number of treatment and rehabilitation services.
National Aboriginal and Torres Strait Islander Substance Use Program	This Program provides recurrent funding to Indigenous drug and alcohol treatment and rehabilitation services across Australia.	$29.22m	This Program delivers holistic and culturally appropriate treatment of drug and alcohol issues and works towards the ongoing recovery of individuals, families and communities. A large proportion of individuals with substance use issues have co-existing mental health issues and services frequently deliver suitable programs and appropriate referral to mental health services and acute health services. Linkages have also been developed with the COAG Mental Health Measure at a number of treatment and rehabilitation services.
NT Sexual Assault Mobile Outreach Service (MOS)	The Sexual Assault Mobile Outreach Service is delivered by the NT Department of Health and Families. It provides culturally safe sexual assault counselling services to Aboriginal children, families and communities in remote Northern Territory communities from regional teams based in larger town centres.	$1.436m [of $6.2 m over 4 yrs from 2008-09 as part of the *Better Outcomes for Hospitals and Community Health* measure]	The Australian Government recognises the importance of responding to symptoms of child abuse related trauma, including sexual assault, which may contribute to adverse mental health outcomes. In 2008-09 the Sexual Assault Mobile Outreach Service provided culturally safe sexual assault counselling services to Aboriginal children, families and communities in remote Northern Territory communities and town camps from regional teams based in larger town centres. MOS teams made 119 visits to 43 communities in 12 remote Health Service Delivery Areas in the NT in 2008-09. This program builds on an initiative funded under the Northern Territory Emergency Response (NTER) in 2007-08.

Deadly Vibe and InVibe Magazines	This measure supports production and distribution of the magazines to subscribers including schools and Aboriginal Medical Services. Deadly Vibe includes information to help people contact their local Aboriginal Medical Service, including a freecall number as well as other health messages. InVibe magazine offers culturally appropriate information about physical, mental and emotional health to youth. Vibe Australia is also funded for • Vibe 3on3™ Basketball Competition Events • Deadly Sounds Radio program • Vibe Website • Deadly Awards	$916,000	An evaluation of Vibe Australia activities found that: The health messages presented in Deadly Vibe magazine address many issues that are particularly relevant to Indigenous youth such as healthy living, lifestyle diseases and anti-substance misuse. InVibe magazine offers culturally appropriate information about physical, mental and emotional health to youth at risk who often have very few alternative sources of information, and certainly none that are Indigenous specific. The content of InVibe is relevant, appropriate and valuable to this group. Among the other findings of the evaluation were: • That the health messages promoted through the 3on3™ Basket ball events are reaching youth and the wider community. There was strong support for the 3on3™ as an appropriate and effective vehicle for promoting healthy lifestyles, fitness and anti-substance misuse. • That there is scope to increase the direct health messages promoted as part of the 3on3™ event, either through increasing the role of the Aboriginal Medical Services, incorporating more engaging health focussed activities or more promotion of health-related slogans and phrases. Introducing a range of follow up activities could also help to extend the life of the event. While direct health outcomes from the Deadly Awards are less easily identified when compared to other Vibe products, it is suggested that the real value of the Deadly Awards can be measured more in terms of the good will generated by the event and the positive spin-offs such as reinforcement of cultural identity and self-esteem that result from the promotion of Indigenous role models and achievements.

Forensic Medical Examinations for Children in Communities (FMECC)	The Northern Territory Department of Health and Families was funded in 2008-09 to provide sexual assault forensic medical examinations to children and young people in or near their local communities. This service complements the Sexual Assault Mobile Outreach Service.	$0.275 m [of $1.5 m for 2009-09 to continue Child Special Services under the $13.6 m over yrs *Closing the Gap – Northern Territory follow-up care* measure]	The aims of the project are to reduce trauma to Aboriginal children, adolescents, families and communities by providing culturally safe forensic sexual assault medical examinations and counselling services in or near their local communities. It also aims to provide services that are valued by Aboriginal families, communities and service providers.
Training for Primary Health Care Staff – child abuse issues	The Centre for Remote Health was funded in 2008-09 to deliver broad-based training to remote primary health care staff on dealing with child abuse and trauma in the Northern Territory. The training commenced in May 2009 and is expected to be completed in November 2009.	$0.663 m [of $1.5 m for 2009-09 to continue Child Special Services under the $13.6 m *Closing the Gap – Northern Territory follow-up care* measure]	The training for remote primary health care staff on dealing with child abuse and trauma will better equip both NT clinic and Aboriginal Medical Service staff with the skills and knowledge needed to deal in the first instance with cases of suspected or substantiated child abuse and neglect and related trauma in a remote setting. Increased access to early and appropriate intervention for the symptoms of child abuse related trauma will assist in minimizing long-term adverse mental health outcomes.

Healthy for Life program One-Off Men's Health Funding	*Healthy for Life* uses a population health approach and quality improvement model to enhance the capacity of primary health care services to improve the quality of Aboriginal and Torres Strait Islander child and maternal health services, men's health and chronic disease care. One-off funding of $2.55m was provided between May '09 and December '09 to 16 services for men's health projects, most of which included engagement and social inclusion activities.	$898,560 for the period ending 30 June 2009.	The activities can be summarised as 'increasing awareness of men's health issues across the physical, spiritual and psychosocial domains, and empowering men to improve and maintain good health.' Many services employed male Aboriginal Health Workers to engage with men and conduct various health screening and promotion activities. Overcoming addictions, physical activity, relationship building activities complemented the goal of increasing access for men to appropriate health services. Broader *Healthy for Life* activities encourage a positive approach to improving personal health. While not focussed on social inclusion or suicide prevention, it is possible that these services contribute to improving general health including social, emotional and wellbeing.
Cooperative Research Centre for Aboriginal Health (CRCAH) - Social and Emotional Well Being Program	A research program to identify pathways and methods whereby resilience can be built on and enhanced to measurably improve the wellbeing and social outcomes or life chances of Indigenous individuals, families and groups. Also, to understand how resilience is promoted within Aboriginal family and social relationships despite the adverse impacts of social change and colonisation.	As one of 12 core partners, DoHA provides $200,000 (annually (totalling 1.4m to June 2010) to the CRCAH but does NOT target any of the specific research programs within the CRCAH to be the recipients of the funds.	Current and recently completed research projects include: • Parenting Support Interventions for Indigenous Families: Let's Start Extension • Australian Integrated Mental Health Initiative (AIMhi) Northern Territory • Indigenous Alcohol and Other Drugs Workers Wellbeing, Stress and Burnout Project • Evaluation of the Central Northern Adelaide Health Service (CNAHS) Family and Community Healing Program Publications from the Research includes McEwan, A & Tsey, K. 2009. *The Role of Spirituality in Social and Emotional Wellbeing Initiatives: The Family Wellbeing Program at Yarrabah - Discussion Paper No. 7*. CRCAH, Darwin. See http://www.crcah.org.au/research/socialandemotionalwellbeing.html

Regulatory Policy & Governance Division

Program Name	Description	Funding Amount (2008-09 GST excl.)	Social Inclusion/ Suicide prevention Achievements
Community Service Obligations (CSO) program.	Under the CSO program hearing services are provided to children under 21 years, adults with complex rehabilitation needs and Indigenous people over 50 and participants of the Community Development Employment Projects (CDEP) until 1 July 2012. Australian Hearing is the sole provider of CSO services which include hearing assessment, rehabilitation and the fitting of hearing devices (if appropriate).	$41.740 million	In 2008/09 the CSO program provided hearing services and hearing devices to 28,710 children under 21 (including 5,372 Indigenous children) and to 16,369 eligible complex clients. The Indigenous specific measures provided hearing services for 2,526 Indigenous people over 50 and those on CDEP Program.

Ageing and Aged Care Division

Program Name	Description	Funding Amount (2008-09 GST excl.)	Social Inclusion/ Suicide prevention Achievements
One-off Discretionary Grants to Assist Frail Older People Experiencing Social Isolation	Depression is a debilitating illness which is a main predicator to suicide. It is often associated with loneliness and social isolation. In the frail and elderly poor health leading to mobility constraints, family breakdown, lack of social networks and financial insecurity are often contributing factors that prevent effective participation in community life. In June 2008, DOHA provided 21 one-off discretionary grants to a range of not-for profit organisations to assist vulnerable, frail older people living in the community experiencing social isolation. The funds were intended to increase the capacity of the organisation to undertake work aimed towards helping the most vulnerable and frail older people in the community.	$4.213m	• Social get togethers brought frail elderly people together to establish social networks. This included gardening, bingo, BBQs, drama and luncheons groups. The focus of these activities was creating community groups that had common interests and could share discussions and activities. • Development of a "Social Inclusion Support Training Manual" which will provide education on the concepts and research on social inclusion and practical applications for a variety of settings. • Provision of food supply shopping vouchers to address food and clothing shortages. • Provision of shelter or emergency accommodation. • Continuing development of a Homeshare program which supports older people (Householders) to remain in their homes and communities for longer by matching a younger person (Homesharer) to live with them. • Provision of occupational therapists to assess the needs of some destitute clients and to recommend the resources and services they need for better health outcomes, including improved social engagement • Provision of furniture and whitegoods for some clients in emergency situations. • 24/7 crisis telephone support and call in capacity for clients in crisis.

Office of Rural Health – Primary and Ambulatory Care Division

Program Name	Description	Funding Amount (2008-09 GST excl.)	Social Inclusion/ Suicide prevention Achievements
Regional Health Services (RHS)*	Improves access to broad range of primary and allied health care services, including mental health services, through funding to existing community-based health services.	$ 48.123 m	There are 118 RHS of which more than half provided mental health, counselling and/or social work services, where these issues were an identified priority need. This program provides services to over 1000 rural and remote communities with a population of less than 5000 people.
More Allied Health Services (MAHS)*	Improves access to a range of allied health care services, including mental health services, through funding to Divisions of General Practice.	$ 16.596 m	There are 66 MAHS of which 41 received funding for 31 full time equivalent psychologists (in 2006-07). Other services provided included counselling and social work. This program provides services to communities classed as 'small rural centres' to 'other remote areas' (RRMA 4-7).

* These programs are being consolidated in the Rural Primary Health Services program from 1 January 2010. Service provision will continue as under the current arrangements. Communities currently receiving services under MAHS and RHS will continue to be priority communities for the RPHS program. Organisations will work with their communities to ensure priority needs are addressed.

Program Name	Description	Funding Amount (2008-09 GST excl.)	Social Inclusion/ Suicide prevention Achievements
Royal Flying Doctor Service Program	Delivery by the Royal Flying Doctor Service of primary aeromedical evacuations and health care clinics in rural and remote Australia	$66 million	The following comments relate to both programs as they are administered by the Royal Flying Doctor Service.
Rural Women's GP Service	The Rural Women's GP Service (RWGPS) aims to improve access to primary health care services for women in rural and remote Australia, who currently have little or no access to a female GP, by facilitating the travel of female GPs to these communities. The RWGPS is open to all members of the community,	$3 million	RFDS health practitioners who deliver GP Clinics and Community Health Nurse Clinics under the Traditional Services program and the RWGPS program are able to identify and refer as necessary patients to specialist mental health providers. RFDS practitioners have skills identifying and understanding mental illness as it relates to indigenous communities.

	including men and children. This program is administered nationally by the Royal Flying Doctor Service.		

Health Workforce Division

Program Name	Description	Funding Amount (2008-09 GST excl.)	Social Inclusion/ Suicide prevention Achievements
Mental Health Nurses and Psychologists Scholarship Subsidy	The Mental Health Nurses and Psychologists Scholarship Subsidy provides scholarships to mental health nurses and psychologists who are undertaking postgraduate study in mental health nursing and clinical psychology. The Government announced the program as part of the 2008-09 Federal Budget, expanding and developing the existing Additional Education Places, Scholarships and Clinical Training in Mental Health Initiative.	$6,973,217	The Australian Government committed $35 million over four years (from 2008-09) to enhance access to postgraduate and masters level scholarships in mental health nursing and clinical psychology to encourage the training of appropriately qualified mental health professionals. Part of this initiative focuses on regional, rural and remote Australia, where access to mental health professionals is more limited. This measure built on the existing Mental Health Postgraduate Scholarship Scheme ($10 million from 2006-2011) and increased the value of scholarships from $10,000 to $15,000 per full-time year of study. The $35 million in additional funding will support: – up to 1070 new postgraduate and Masters degree scholarships for mental health nursing, of which 105 will be designated for rural and remote areas; and – up to 222 new rural and regional scholarships for postgraduate and masters studies in clinical psychology. For the 2009 cohort, 244 mental health nursing scholarships and 112 clinical psychology scholarships were awarded under the Mental Health Postgraduate Scholarship Scheme.

Medical Benefits Division

Program Name	Description	Funding Amount (2008-09 GST excl.)	Social Inclusion/ Suicide prevention Achievements
Medicare Benefits Schedule (MBS) Indigenous Health Assessments (MBS items 704, 706, 708, 710)	GP health assessments for Indigenous people (children under the age of 15, adults to the age of 54 and older people 55+)	$7,211,585 paid in MBS rebates for MBS Indigenous health assessment items	These MBS health assessment items help to ensure that Aboriginal and Torres Strait Islander people receive appropriate health care by encouraging early detection, diagnosis and treatment of common and treatable conditions, and includes a social and emotional assessment. They also help to improve Indigenous people's access to mainstream primary medical care and help reduce or prevent serious illnesses. Since the introduction of the first Medicare Indigenous health assessment item in 1999 (the older persons assessment), 132,172 services have been provided. In 2004-05, 9,957 health assessment services were provided to Indigenous people. This rose to 37,783 services by 2008-09 (an increase of 379%). In the first three months of 2009-10, 11,573 services were provided, and it is anticipated that the increase in service provision will continue to climb.

Follow up service provided by a practice nurse or registered Aboriginal Health Worker, on behalf of a Medical Practitioner, for an Indigenous person who has received a health assessment (MBS item 10987)	Follow-up services provided by a practice nurse or registered Aboriginal Health Worker to an Indigenous person who requires further treatment following a health assessment	$12,343 paid in MBS rebates for the Indigenous health assessment follow-up item	The Indigenous health assessment follow-up item was introduced on 1 November 2008, and the available data is limited. In 2008-09, 556 services were provided. To September 30 2009, 418 services have been provided.
MBS services to rural and remote areas	MBS Non-Referred general practitioner attendances	The MBS Special Appropriation, which is demand driven.	In the period between 2004-05 and 2007-08, total non-referred GP attendances in both urban and rural and remote areas increased by almost 2.6%. In rural and remote areas, the number of Full-Time Workforce Equivalent (FWE) GPs increased from 77.3 FWE GPs per 100,000 people in 2004-05, to 79.9 FWE GPs per 100,000 people in 2007-08. This is an increase of almost 3.4 %.
MBS services to Indigenous people	MBS Non-Referred general practitioner attendances	The MBS Special Appropriation, which is demand driven.	In the period between 2005-06 and 2007-08, the number of non-referred GP services provided to Indigenous people increased by 23%.

APPENDIX B. DOHA Mental Health Programs

Program Name	Funding and Description	Purpose
Better Access to Psychiatrists, Psychologists and General Practitioners	Funding of $753.8 million over five years (2006-2007 to 2010-2011) has been committed as part of the Australian Government's contribution to the COAG *National Action Plan on Mental Health (2006 - 2011*).	The initiative encourages a team-based, multidisciplinary approach to mental health care in the community for patients with a clinically diagnosed mental disorder. Medicare items are available for up to 12 individual and/or 12 group allied mental health services per calendar year, to patients with an assessed mental disorder who are referred by a medical practitioner managing the patient under a General Practitioner Mental Health Care Plan, or under a psychiatrist assessment and management plan, or a psychiatrist, or paediatrician.
Better Outcomes in Mental Health Care The program comprises two components: • Access to Allied Psychological Services (ATAPS) • GP Psych Support Service	The 2001-02 Budget provided $120.4 million over four years and further funding of $142.7 million was provided in July 2006 to continue the program until 31 December 2009. This program has been identified as an ongoing program.	This program aims to improve the quality of care provided through general practice to Australians with a mental illness. The *ATAPS component* provides funding for GPs to refer consumers, who have been diagnosed as having a mental health disorder, to an allied health professional to provide low cost focused psychological strategies. The Royal Australian College of General Practice is currently engaged to deliver the *GP Psych Support Service*. This service provides GPs with phone, fax and internet/email access to patient management advice from a psychiatrist within 24 hours (or 48 hours for specialised drug and alcohol or child and adolescent mental health matters) of their request.
National Perinatal Depression Initiative	An $85 million joint Commonwealth-state plan for perinatal depression to improve prevention, early detection, support and treatment for expectant and new mothers.	The initiative will enable provision of: • routine screening for depression - once during pregnancy and again around two months after the birth; • follow-up support and care for women who have been assessed as at risk of or experiencing antenatal or postnatal depression; and

		• training for health professionals to help them screen expectant and new mothers and identify those at risk of or experiencing depression and make appropriate referrals using the various pathways available; and research and data collection.
Youth Mental Health Initiative	$45 million over the next three years to June 2012 for the Youth Mental Health Initiative, which provides funding through *headspace,* the National Youth Mental Health Foundation, to provide 30 youth friendly shopfronts across the country for young people aged 12 – 25 years old.	**headspace** provides a national, coordinated focus on youth mental health and related drug and alcohol problems in Australia and aims to improve access for young people aged 12-25 years to appropriate services and ensure better coordination between services. Specifically it: 1. provides a centre of excellence that promotes evidence-based practice in youth mental health; 2. increases knowledge, understanding and skills of GPs and other service providers working with young people; 3. fosters community awareness of youth mental health issues to encourage young people to seek assistance early; and 4. supports local integrated approaches to improve the coordination of services for young people with mental health problems through local Communities of Youth Services sites CYS sites. To complement this activity, funding has been allocated to the Youth Mental Health Initiative - Allied Health Workers program which will extend and enhance the range of services available at the CYSs. The funding provided enables young people aged 12-25 years to have access to the services of psychologists, drug and alcohol counsellors and other allied health professionals at the 30 newly established CYSs across Australia.
Mental Health Nurse Incentive Program	The Program provides $49.5 million over four years from 2008-2009 to 2011-2012, and is part of the Australian	The Program provides non-Medicare Benefits Schedule incentive payments to community based general practices, private psychiatrist services and other appropriate organisations (such as Divisions of

	Government's component of the COAG *National Action Plan on Mental Health (2006 - 2011)*.	General Practice) who engage mental health nurses to assist in the provision of coordinated clinical care for people with severe mental disorders. Services are being provided in a range of settings, such as in clinics or patients' homes, and are to be provided at little or no cost to the patient. Close and effective collaboration between mental health nurses, general practitioners and psychiatrists in the delivery of clinical support and services in the community will: • improve levels of care for people with severe mental disorders; • reduce the likelihood of unnecessary hospital admissions and readmissions for people with severe mental disorders; and • assist in keeping people with severe mental disorders well, and feeling connected within the community.
Mental Health Response to the Victorian Bushfires	$7.5 million ($4.5 million in 2008-09 and a further $3 million in 2009-10) for the provision of mental health support to individuals and communities affected by the Victorian bushfires	The $3 million announced as part of the 2009-2010 budget is in addition to the $4.5 million allocated in 2008-2009 to: • increase funding under Access to Allied Psychological Services (ATAPS) to nine Divisions of General Practice to enable ongoing provision of specialised services to people with persisting psychological symptoms; • increase the capacity of increase telephone counselling services; • aid the psychological recovery of communities over the longer term by encouraging mental health promotion activities with a focus on children and people isolated as a result of the bushfires; and • deliver specialised training and support to GPs, general nurses and specialist mental health practitioners.

Early Intervention Services for Parents, Children and Young People measure	$12.2 million extension of the KidsMatter Primary Schools initiative to a further 300 schools following its pilot project in 101 schools, and the associated $6.5 million project for the early childhood sector, was announced by the Minister on 5 October 2009.	The *KidsMatter* Primary School Pilot has three major aims: • improve the mental health and well-being of primary school students; • reduce mental health problems among students (eg anxiety, depression and behavioural problems); and • achieve greater support for those students experiencing mental health problems.
beyondblue: the national depression initiative	*beyondblue* is a collaborative initiative funded by the Australian, state and territory governments. It was launched in 2000. Over a period of ten years (2000-2010), *beyondblue* will have received $66.2 million (excluding GST) from the Australian Government.	*Beyondblue* works in partnership with governments, business, professional, sporting and community organisations, academia and the media, as well as people living with depression, across five priority areas around depression, anxiety and related disorders: • community awareness and destigmatisation utilising the media, community leaders and health professions, consumers and carers; • community and carer participation through electronic networks and dedicated websites; • prevention and early intervention programs in areas including postnatal and antenatal depression, children and young people, families, older people, and depression in the workplace; • primary care such as improving training and support for general practitioners and other health care professionals; and • initiate and support depression-related research.
Telephone Counselling, Self Help and Web-Based Support Programmes	This measure aims to increase the provision of evidence based telephone and web-based counselling and information services, and expand and enhance on-line interactive tools. The measure provides $60.9 million over five	Activities being funded include enhancement of general psychosocial helplines (including Lifeline and Kids Helpline), online self help resources, and self directed online treatment modules. New services were funded in 2007-2008 that utilise the internet to provide therapeutic support and resources across Australia for people

	years (2006 to 2011), and is part of the Australian Government's component of the COAG *National Action Plan on Mental Health (2006 – 2011)*.	with mental health problems, their families and carers. These services include on-line peer support, counselling, cognitive behavioural programs for depression and anxiety disorders and a system that helps people track their wellbeing in areas including mood, appetite, sleep, medication, physical activity, and drug and alcohol use.
Mental Health Services in Rural and Remote Areas program	The Program commenced in 2006-2007 and provides $59.857 million over five years to 2010-2011 as part of the Australian Government's component of the COAG *National Action Plan on Mental Health (2006 - 2011*).	This Program funds eligible organisations in rural and remote areas to engage allied and nursing mental health professionals to provide mental health services to clients with a diagnosable mental illness. These services include those provided by social workers, psychologists, occupational therapists, mental health nurses, Aboriginal health workers and Aboriginal mental health workers. The Program aims to increase services delivered through a flexible model of care, with medical practitioner oversight, in rural and remote areas including those affected by drought throughout Australia.
Mental Health Support for Drought Affected Communities	$10.1 million has been allocated over the two years 2007-08 and 2008-09. The majority of funding is allocated to over 40 eligible rural and remote Divisions of General Practice to provide community outreach and crisis counselling.	This Program aims to build the capacity of rural and remote drought affected communities to respond to the psychological impacts of drought. Community awareness activities and education and training for health workers and community leaders is being provided in eligible Divisions. Implementation commenced in July 2007. Whilst most eligible Divisions have engaged community support workers, some have experienced delay in implementation due to difficulty recruiting suitable personnel.
The Program of Assistance for Survivors of Torture and Trauma (PASTT)	PASTT is funded a total of $14.6m over three years (2008/09-2010/11) During 2009-10, eight specialist torture	The Program of Assistance for Survivors of Torture and Trauma (PASTT) aims to deliver medium to long term torture and trauma counselling services to humanitarian entrants who have pre-migration experiences of conflict and human rights abuses, which make them vulnerable to

	and trauma agencies across each of the states and territories are funded a total of $4.879 million to continue to provide individual and group counselling, education for mainstream service providers and community capacity building activities	developing mental health problems. The overall capacity of the program has enabled 3,107 clients to receive counselling services during the 2008-2009 year.
Support for Day-to-Day Living in the Community	The Support for Day to Day Living in the Community (D2DL) program provides $45.5 million over five years 2006-2011. Funding to organisations providing the D2DL program totalled $8.74 million in 2008-09.	The Support for Day to Day Living in the Community (D2DL) program aims to improve the quality of life for individuals with severe and persistent mental illness by providing an additional 7,000 places in structured and socially based activity programs. The initiative recognises that meaningful activity and social connectedness are important factors that can contribute to people's recovery. The aims of the D2DL program are to: • support people with severe and persistent mental illness who experience social isolation • increase the ability of people with severe and persistent mental illness to participate in social, recreational and educational activities • assist people with severe and persistent mental illness to improve their quality of life and live successfully at an optimal level of independence in the community • expand the capacity of the NGO sector to offer structured day programs for people experiencing social isolation through severe and persistent mental illness and • increase community participation by assisting participants to:

		o develop new skills or relearn old skills o develop social networks o participate in community activities o develop confidence and o accomplish personal goals.

APPENDIX C. Australian Government programs and initiatives targeting alcohol and other drug problems

The *Australian Drug Trends 2008: Findings from the Illicit Drug Reporting System Report*[3] indicated that over the past few years, an increasing focus has been placed on comorbid substance use and mental health disorders.

The relationship between mental health and substance use is complex, with several potential ways in which they are related. Three main approaches have been taken to explain the relationship between substance use and mental health problems (Teesson & Burns, 2001). The first suggests that substance use may cause or exacerbate mental health problems via biological or environmental pathways. Secondly, it has been proposed that mental health problems may predispose an individual to substance use, e.g. through disinhibition, as a means of self-medicating psychological distress, or as a coping mechanism. The third theory argues that common factors may predispose individuals to both mental health and substance use disorders (e.g. biological, environmental and/or social factors; Degenhardt et al., 2003, de Graaff and Bruno, 2007). These causal pathways may vary across drug types and psychiatric symptomatology (Jane-Lopis and Matytsina, 2006). Furthermore, comorbid disorders are now recognised to be widespread and associated with poorer treatment outcomes, high levels of service utilisation and more severe disability (de Graaff and Bruno, 2007, Teesson and Burns, 2001).

Australian Government policy

The Australian Government's activities in the licit and illicit drug area fall under the umbrella of the *National Drug Strategy 2004-2009* (NDS). The Strategy provides a framework for a coordinated, integrated approach to drug issues in the Australian community.

Endorsed by the Ministerial Council on Drug Strategy (MCDS), which comprises Australian Government and State and Territory health and law enforcement agencies, the NDS aims to improve health, social and economic outcomes by preventing the uptake of harmful drug use and reducing the harmful effects of licit and illicit drugs in Australian society.

There are also a number of national strategies under the NDS that guide and coordinate the work of the Commonwealth and State and Territory Governments. These include:

- National Alcohol Strategy 2006-2011.
- National Amphetamine-Type Stimulant Strategy 2008-2011.
- National Cannabis Strategy 2006-2011.
- National Strategy to Prevent the Diversion of Precursor Chemicals into Illicit Drug Manufacture.
- National Drug Strategy Aboriginal and Torres Strait Islander Peoples. Complementary Action Plan 2003-2009.
- National School Drug Education Strategy.
- National Corrections Drug Strategy 2006-2009.

Programs and initiatives funded by the Australian Government

The Department of Health and Ageing (DOHA) funds a number of programs under these strategies with the goal of reducing the use of licit and illicit drugs. These programs reduce the health, social and economic harms to individuals and the community arising from drug use. This includes improvement in general health, social functioning and a reduction in crime, including violence.

Key initiatives include:

National Binge Drinking Strategy

Under the National Binge Drinking Strategy the Australian Government has been working to confront young people with the consequences of binge drinking and to take responsibility for their behaviour.

Key measures to help reduce alcohol misuse and binge drinking among young Australians include:

- $14.4 million to invest in community level initiatives to confront the culture of binge drinking, particularly in sporting organisations;
- $19.1 million to intervene earlier to assist young people and ensure that they assume personal responsibility for their binge drinking; and
- $20 million for advertising that confronts young people with the costs and consequences of binge drinking. It is also designed to increase the likelihood that for those teenagers and young adults who choose to drink alcohol, they do not drink to levels of intoxication which may result in harm to themselves or others. This Campaign carries with it a tag line of "Don't Turn your Night Out into a Nightmare"

Illicit Drug Use – Targeting Young Methamphetamine Users (The National Drugs Campaign)

The Targeting Young Methamphetamine Users campaign aims to develop, reinforce and build awareness and understanding of the risks associated with the use of methamphetamines (speed and ice), ecstasy and cannabis; encourage avoidance; promote reduction and/or cessation of the use of these substances and directs users to relevant support, counselling and treatment services.

This $17.9 million education campaign provides young Australians with up-to-date information about methamphetamine, ecstasy and cannabis.

National Psychostimulants Initiative

The National Psychostimulants Initiative (NPI) aims to reduce harms and prevent harms associated with psychostimulant use in the Australian community.

The NPI has $11.3 million in funding until 2011-12 to undertake research, develop the drug and alcohol workforce, disseminate evidence based information to help reduce the impact of psychostimulant drugs in Australia, and educate young Australians about the risks and harms associated with psychostimulant drug use including ice.

Non-Government Organisations Treatment Grants Program

The Non-Government Organisation Treatment Grants Program (NGOTGP) provides funding to non-government organisations (NGOs) to operate a range of alcohol and drug treatment services. Under round three of the NGOTGP the Commonwealth Government is providing $134.4 million (2008-2011) to 197 non-government treatment services. Treatment options available under the NGOTGP include counselling, outreach support, peer support, home detoxification, medicated and non-medicated detoxification, therapeutic communities and in/out patient rehabilitation.

Alcohol and Drugs Treatment Services National Directory

In 2008, DOHA, together with State and Territory Governments, developed an Alcohol and Drugs Treatment Services National Directory (www.aodservices.net.au). The Directory has been designed for people who have concerns about their own or other's alcohol or drug use and provides the ability to search for treatment services located in a particular State or Territory. The Directory assists the public and health workers to make informed decisions in relation to referral into alcohol and drug treatment.

Improved Services Initiative for People with Coexisting Mental Health and Drug Use Disorders

The Improved Services Initiative is providing approximately $20 million per annum to 2011-12 to fund NGO alcohol and other drug (AOD) treatment services to build their capacity to effectively address and treat coinciding mental illness and substance abuse.

Under the capacity building grants component of this initiative the Australian Government is providing a total of $44.8 million over three years to 122 non-government organisation AOD treatment services across Australia. The grants support workforce training, developing partnerships with local health services and the implementation of policies and procedures that support the identification and management of clients experiencing comorbid substance abuse and mental illness.

Amphetamine-Type Stimulants Grant Program

The Amphetamine Type Stimulants (ATS) Grants Program was a one off grants round (2007-08 to 2008-09) to support time limited capacity building in AOD treatment services to better equip these services to focus on the needs of amphetamine type stimulant users. Funding was used to provide infrastructure and training to better equip services to manage and treat the challenging behaviours that accompany ATS use and subsequent withdrawal and abstinence.

Research

Cannabis and suicide links

Some research on the link between cannabis and mental health has found an association between cannabis use and suicidal thoughts and behaviours, particularly for younger people. Although some of these studies have not controlled for a number of confounding variables, there is general agreement that cannabis use is a risk factor for poor mental health. In particular, heavy use and earlier age of initiation of cannabis use is associated to later experience of psychosis (particularly amongst those that may have a genetic vulnerability to mental illnesses) and depression. In addition, cannabis use is also associated with other known risk

factors for suicide such as poorer educational achievement, disengagement from school and unemployment.

The Australian Government funds the National Cannabis Prevention and Information Centre (NCPIC) to reduce the use of, and harms associated with cannabis. The National Drug and Alcohol Research Centre (NDARC) is the lead consortium partner of NCPIC. Other consortium members are: the National Drug Research Institute; Australian Institute of Criminology, Lifeline, Orygen Research Centre, Ted Noffs Foundation, and the National Centre for Education and Training on Addiction.

Specific activities of NCPIC aimed at providing support for those experiencing cannabis related mental health issues include:

- The development of resources such as guidelines for the management of cannabis use disorder and related issues and the "Helping someone with problem cannabis use mental health first aid guidelines". The cannabis mental health first aid guidelines aim to inform members of the community on how to recognise when someone's cannabis use has become a problem, how to provide initial support and information, and how to guide the person to seek appropriate professional help. The guidelines also advise how to encourage a person with problem cannabis use to seek other help options (such as informal support groups) and provide information on what to do if the person does not want help with their problems (project undertaken by Orygen Youth Health as a consortium member of NCPIC).

- "Making the Link" which is a curriculum based school program to promote helpseeking for cannabis and mental health problems. The program aims to teach students how to help each other to seek professional help. It promotes the idea that mates help mates. It reduces the barriers to seeking help, while also educating teachers to assist students to access professional help.

- NCPIC is also undertaking the development of a unit on cannabis and mental health that can be offered within a Certificate level course (e.g. Cert IV in AOD Work). The unit will provide an introduction to problematic cannabis use in individuals with mental health issues and interventions that can be used to reduce the impact of cannabis in these people (project undertaken by Orygen Youth Health as a consortium member of NCPIC).

- NCPIC has established a free, national Cannabis Information and Helpline (CIH) which provides callers with evidence based information on cannabis as well as targeted advice and brief interventions for cannabis users, their families and concerned others. The helpline is run by NCPIC consortium partner, Lifeline.

- DOHA has produced a National Drug Strategy Monograph (68) called *Cannabis and Mental Health: put into context* which provides among other things, information regarding studies relating to depressive symptoms or diagnosis of major depressive disorder, some of which assess the relationship between cannabis use and suicidal behaviour.

- The NCPIC website (www.ncpic.org.au) provides additional links and information, including fact sheets on mental health.

Suicide Risk Assessment Study

DOHA has funded a Suicide Risk Assessment Study through the National Drug and Alcohol Research Centre (NDARC). Since suicide represents a major clinical challenge to those treating AOD users, it is essential that AOD workers have an awareness of, and clinical expertise in, identifying and treating clients who are at risk. The focus of existing assessment tools appears to be on identifying current suicidal ideation and intervening in the acute stage.

The need for the current study came about from:

- the relative risk of completed suicide for people who use a range of drugs is significantly higher than that of the general population
- alcohol and other drug users have an extremely high prevalence of other risk factors (e.g. demographic characteristics, psychopathology, family dysfunction, social dysfunction/isolation) when compared to the general population
- rates of both completed and attempted suicide amongst AOD users are many times greater than those observed among the general community.

The objectives of the study are to:

- provide a detailed description of the current practices of AOD workers regarding suicide risk assessment and intervention, and their knowledge of suicide risk factors among people with substance use disorders
- identify additional and/or under-utilised opportunities for intervention
- identify how the treatment setting might be used to more effectively identify and respond to suicide risk
- inform the potential development of a suicide risk assessment tool and decision tree for guiding treatment (for use by AOW workers)
- outline the core components of the potential suicide risk assessment tool
- make recommendations about how the assessment tool could be developed and disseminated in order to maximise its usefulness.

A suicide assessment tool for AOD workers will be highly valuable in identifying and treating clients at risk and highlighting areas where additional intervention is possible. The study is due for completion at the end of 2009.

Evidence underpinning the initiatives

DOHA supports a number of data sources which inform the development of policy and the management programs. These include:

National Drug Strategy Household Survey (NDSHS)

The NDSHS is the most comprehensive national survey on substance use and related issues, and is the principal data collection vehicle to monitor trends and evaluate progress under the NDS. The survey is conducted on an approximately triennial basis with the next one scheduled for 2010. The survey examines the status of drug use, patterns of consumption, community support for drug-related policy, drug-related activities and drug-related harm.

NDSHS prevalence of drug use

- In 2007, close to two-in-five (38.1%) Australians aged 14 years and over had used an illicit drug at least once in their lifetime, while almost one-in-seven (13.4%) had used an illicit drug in the last 12 months.
- In 2007, recent illicit drug use (i.e. in the 12 months) was significantly lower than in 2004 (13.4% compared to 15.3%, respectively) and lower than any estimate since 1993. Contrary to this trend, recent use of cocaine significantly increased from 1.0% in 2004 to 1.6% in 2007.
- Cannabis, ecstasy, pain killers/analgesics (for non-medial purposes) and methamphetamines were the most commonly used illicit drugs.
- In 2007, less than one in six (16.6%) of the population aged 14 years or older reported smoking daily, declining from 17.4% in 2004.
- In 2007, about one-third (34%) of persons aged 14 years or older put themselves at risk of high risk of alcohol-related harm in the short term on at least one drinking occasion during the previous 12 months.

NDSHS psychological distress and patterns of drug use

- In 2007, approximately seven in ten people aged 18 years or older reported low levels of psychological distress (69.0%). Almost one in ten (9.9%) reported high or very high levels of psychological distress.
- Daily smokers (16.7%) were more likely than other recent smokers (10.2%) or non-smokers (8.3%) to report high or very high levels of psychological distress
- High-risk drinkers (15.3%) were twice as likely as low-risk drinkers (8.5%) to experience high or very high levels of psychological distress.
- One in five (20.2%) people who used an illicit drug in the past month reported high or very high levels of psychological distress.
- Approximately two-thirds of people (64.8%) who used heroin in the past month reported high or very high levels of psychological distress.

Illicit Drug Reporting System (IDRS)

Australia also surveys regular drug users and collects information on user demographics, user behaviours and illicit drug availability, price and purity. For example, the IDRS is an annual survey of approximately 1,000 injecting drug users.

IDRS mental health indicators

Forty-three percent of the IDRS sample self-reported that they had experienced a mental health problem in the preceding six months, most commonly depression (75% of respondents) and/or anxiety (43%). Just over half (53%) of the participants who reported experiencing a mental health problem had been prescribed medication for this problem during the past six months, most commonly antidepressants (33%; 14% of the entire sample) and/or antipsychotics (15%; 6% of the entire sample).

Higher levels of psychological distress as measured by the Kessler Psychological Distress Scale (K10) were reported than among the Australian general population, with 28% reporting 'high' distress (this compares to 8% in the general population) and 27% reporting 'very high' distress. Those reporting a 'very high' level of distress have been identified as possibly requiring clinical assistance (IDRS report 2008).

Alcohol and Other Drug Treatment Services National Minimum Data Set (AODTS-NMDS)

The AODTS-NMDS collects data on completed treatment episodes provided by publicly funded AOD treatment services. The purpose of the AODTS-NMDS is to aggregate standardised data from the Australian, State, and Territory Governments so that national information about clients accessing AOD treatment services, including service utilisation and treatment programs can be reported.

Drug and alcohol treatment services play an important role in suicide prevention. Accessible services for people with co-existing mental health and drug and alcohol misuse contributes to prevention of self-harm.

AODTS NMDS treatment statistics

In 2007-08, a total of 658 government funded alcohol and other drug treatment agencies across Australia supplied data. These agencies delivered around 154,000 treatment episodes, an increase of about 7,000 episodes compared to 2006-07. Alcohol was the most common drug of concern for people seeking treatment (44% of all treatment episodes), followed by cannabis (22%), heroin (11%) and amphetamines (11%). Counselling was the most common treatment provided at about 2 in 5 episodes (37% of episodes), followed by withdrawal management (16%), assessment only (14%) and information and education only (10%).

Work is currently underway investigating the feasibility of including mental health indicators within the AODTS NMDS.

Australian Secondary Students' Alcohol and other Drugs Survey (ASSAD)

The ASSAD collection is a national survey of students aged 12 to 17 years on the use of tobacco, alcohol and illicit drugs and is conducted triennially. The last survey for which results are available was conducted in 2005 of which there were 21,805 respondents surveyed in 376 schools. Results from the 2008 survey are expected to be released in late-2009.

ASSAD prevalence statistics

- 29% of students aged between 12-17 years had consumed alcohol in the week prior to the survey, this increased with age, peaking at 49% for students aged 17 years. About 5% of 12–15 year olds and 20% of 16–17 year olds drink at a risky or high-risk level for harm in the short-term.

- In 2005, smoking rates for both 12-15 year olds (7% smoking weekly) and 16-17 years olds (17% smoking weekly) were at the lowest levels recorded over the last two decades.
- The proportion of students aged 12-17 years who used an illicit drug in the month before the survey decreased from 15% in 1999 to 8% in 2005.
- The proportion of students aged 12-17 years who used cannabis in the month before the survey decreased from 14% in 1999 to 7% in 2005.
- Recent use of ecstasy (i.e. in the last 12 months) has remained stable between 2004 (3.4%) and 2007 (3.5%). However, the proportion of teenage girls having recently used ecstasy has continued to increase, from 4.3% in 2001, to 4.7% in 2004 and 6.0% in 2007.
- The proportion of students aged 12-17 years who used meth/amphetamine in the month before the survey has decreased marginally since 2002 from 3% to 2% in 2005

Alcohol-related suicides[4]

A range of programs exist under the *National Alcohol Strategy* and the *National Binge Drinking Strategy* that tackle a variety of alcohol-related harms, including alcohol-related suicide.

All ages[5]

- Between 1992-2001, there were an estimated 2,495 deaths as a result of alcohol-related suicide (approximately 250 deaths per year).

Young people- deaths[6]

- Suicide is the second largest cause of alcohol-related death for young Australians.
- Young men are much more likely than young women to die as a result of alcohol-related suicide.
- Between 2001-2005, there were an estimated 29 deaths as a result of alcohol-related suicide for people aged 0-17 years (approximately 6 deaths per year).
- Between 2001-2005, there were an estimated 169 deaths as a result of alcohol-related suicide for people aged 18-24 years (approximately 34 deaths per year).

Young people-hospitalisations

- Young women are more likely than young men to be hospitalised as a result of alcohol-related attempted suicide.
- In 2004-05, there were an estimated 906 hospitalisations as a result of alcohol-related attempted suicide for females aged 0-19 years.
- In 2004-05, there were an estimated 287 hospitalisations as a result of alcohol-related attempted suicide for females aged 20-24 years.

[4] The following data were derived using the aetiological fraction method. That is, they are estimates of alcohol-related suicides, not actual figures. 'Alcohol-related' deaths are those deaths where the presence of a drug was considered to have had a substantial enough influence on the fatal incident to be coded as an object involved in the death

[5] *Australian Alcohol Indicators: 1990-2001*, NDRI.

[6] The National Drug Research Institute provided these (unpublished) data for the National Binge Drinking Campaign.

APPENDIX D. Projects currently funded under the National Suicide Prevention Program

Project Details	Objectives	Outcome
Project: Farm-link: improving the mental health and wellbeing of people on NSW farms **Organisation:** Centre for Rural & Remote Mental Health – University of Newcastle **Location:** Rural NSW	The aim of Farm-Link is to improve access to and the responsiveness of mental health services for NSW farming communities through: • Identifying target communities; • Developing NSW Farmer's Mental Health Networks in rural areas; and • Improving e access to effective mental health services for farmers and farm families.	• Twelve target communities identified across 4 Area Health Service regions as having the greatest potential need for people at risk of mental health and suicide. • 17 Farmers' Mental Health Networks meetings held and 13 Mental Health First Aid Training (MHFA) courses conducted with 220 front line agricultural workers. • The MHFA training improved mental health literacy in farming communities and disseminated information about pathways to care. • Independent evaluation of Farm-link found an increase in networking between services, making referral recommendations and working together on programs. Agency links to mental health related services increased in three areas.
Project: Life Matters – Comprehensive Suicide Prevention Service (CSPS) Project **Organisation**: Lifeline Newcastle & Hunter **Location:** NSW: Newcastle, Lake Macquarie, the Hunter, New England and Mid North Coast regions	The Life Matters project is a prevention, intervention and postvention model. The key aims of this project are to: • Build resilience and promote wellbeing and social connectedness across the entire community; • Improve community attitudes and awareness to better identify and help people at risk of suicide; • Within communities, improve access to and provide additional resources, support and services for people who are at risk of suicide; and • Improve support for those who are bereaved or affected by suicide and reduce the potential for further suicides.	• 25 Community Education courses provided to 188 participants in communication skills; building personal resilience; grief & loss; and anger management. • 36 suicide awareness presentations including two community forums provided to 465 participants. • Community members and frontline community service agency staff trained in suicide intervention skills. • 40 Applied Suicide Intervention Skills Training (ASIST) workshops conducted for 725 participants. • 411 clients provided with 2573 hours of face to face counselling, 881 hours of which were provided for clients experiencing suicide and/or depression. • A support pack produced and distributed to relatives and friends of those bereaved by suicide and Suicide Memorial

		Services conducted. • Increase in community awareness of suicide, increase in support services and an increase in the number of people being aware of the availability of suicide intervention counselling services.
Project: The Community Connections Project **Organisation:** Consumer Activity Network (Mental health) Inc (CAN) **Location:** Sydney, NSW	The Community Connections Project aims to support mental health consumers through: • The Hospital to Home Service which provides practical assistance and peer support to mental health consumers within the first 28 days of discharge from the Liverpool and Campbelltown psychiatric inpatient units; and • The Phone Connections Service - a national telephone peer support non crisis line for mental health consumers targeting Sydney. The Service operates 4 evenings a week and is a consumer operated service which involves developing facilitation with a person with similar life experiences.	• From June 2007 to May 2009, 81 consumers accessed the Hospital to Home service and 1225 were visited while in hospital. • 2939 contact episodes from 137 consumers to Phone Connections. Users with suicide attempts were repeat and high users of the service and the majority were from NSW. • An evaluation reported that the majority of consumers found the support provided by peers highly valuable and believed that their interaction with the services increased their level of social connectedness, self-esteem, hopefulness and capacity to maintain wellness. • 15 hospital re-admissions for consumers using the Hospital to Home service which is considered a low level of re-admission.
Project: Koori Kids Wellbeing Project **Organisation**: South Coast Medical Service Aboriginal Corporation **Location**: Shoalhaven, NSW	The four key objectives of this project are: 1) To provide cultural awareness and whole-of-school mental health promotion programs (based on Mind Matters and Aussie Optimism programs) to improve the emotional and social wellbeing of aboriginal children attending targeted local primary schools; 2) Provide intensive counselling and psychological support for aboriginal children with existing emotional wellbeing and behavioural problems, school truancy or underachievement; 3) A parent education program (based on Indigenous Positive Parenting Program & Triple P) to support aboriginal parents improve their parenting skills and have a positive impact on the emotional and behavioural wellbeing of their child/children;	The key outcomes against these objectives include: 1) Programs provided regularly in 4 targeted primary schools to over 200 students: - 2 schools showed significant improvements in emotional awareness, cultural knowledge and help seeking skills; - 2 schools showed significant improvements in parental involvement. 2) Counselling and psychological support services provided - most clients received 3 or more individual/family sessions and showed significant improvements in wellbeing and behaviour. 3) Indigenous specific parenting program data showed increased parental skills and improved ability to support their children and children showed a reduction in emotional distress and behavioural symptoms.

	4) Provide education and training about mental health and the wellbeing of aboriginal children for local services.	4) A series of training and education initiatives, including mental health and parenting training provided for over 10 local community/health services. The project gained wide community support from parents, local elders and community services.
Project: Building Men's Resilience and Community Capacity in Outer Western Sydney **Organisation:** Men's Health Information and Resource Centre **Location:** Mt Druitt, Sydney NSW	The key objectives of this project are to: 1) Provide practical, emotional and referral services for men aged 16 years and over from 'the Shed'; 2) Improve existing relationships with local services and integrate them into a one-stop-shop at the Shed; 3) Provide support to adult males who have attempted suicide; relatives/friends who are bereaved by loss of close relatives/friends to suicide; and families/friends affected by their relatives/friends' suicide attempts; 4) Strengthen relations with the local Indigenous community and re-establish involvement of local Aboriginal elders in the project.	The key outcomes against these objectives include: 1) An average of 10 men per day access the Shed for direct client support. 2) The Shed is well integrated with local services - 15 agencies provide regular satellite services at the Shed. Services include drug and alcohol, health, mental health, family support, legal, housing, employment and education services. Men are also able to access a range of training courses. 3) Staff are able to easily direct relatives and friends to appropriate local services through integration with local services. 4) Local Aboriginal elders are actively involved in the Shed and participate in cultural activities including yarn-ups and monthly overnight bus trips, are members of the Board, and provide support for Indigenous clients.
Project: Expanded Horizons **Organisation:** Wesley Mission Brisbane **Location:** QLD	This project focuses on supporting refugee and Lesbian, Gay, Bisexual, Transgendered (LGBT) youth as an early intervention and prevention program to reduce suicide. The project aims to: • Develop participants' positive connections to their identity; • Strengthen participants' family support networks; • Reduce disengagement with learning and/or re-engage participants into education; • Raise awareness within the local community and within school communities about tolerance and acceptance of young people and social and cultural differences; • Increase participants' access to support services; • Build resilience, improve life skills and increase appropriate	• All 22 of the youth from refugee backgrounds engaged in the project either remained in education or gained employment. • Increased resiliency developed through increased positive peer networks, one on one support from workers to work through challenging situations and improved self-esteem. • Participants gained problem solving, resiliency, conflict resolution and coping skills to assist them to overcome challenging situations. • 24 community events, 186 partnership/collaboration events and 190 individual client services provided.

	and relevant coping strategies for the target groups.	
Project: Community Connections **Organisation:** The Older Men's Network **Location:** QLD	The Community Connections Project aims to: • Provide individual outreach peer support to fifty older men within the settings in which they live; • Further consolidate and enhance existing rural groups and assist in the establishment of new rural groups in high need/risk areas; • Increase community awareness of older men's needs and its support for the project; • Establish a steering committee that will govern the functions of the project.	• 63 men were provided with services and 83 assessments of clients were conducted. • 24 existing members became volunteers to add value to the existence of other older men. • 37 volunteers in total were trained over three years. • 7 rural men's groups established over the life of the Project; Goondiwindi, Chinchilla, Kingaroy, Roma, Mitchell, Injune and Inglewood, and continuation of support for previously established rural men's groups in other communities. • 53 community events were held, 467 individual client services provided, and 128 media/partnership events were held.
Project: Building Bridges **Organisation:** The Centre for Rural and Remote Mental Health **Location:** Cape York, Dalby and St.George area, QLD	The Building Bridges project aims to: • Support leadership and collaboration among local men in suicide prevention; • Harness the capacity of the Family Well Being program to develop life promotion skills in the broader community; • Obtain a better understanding of the meaningfulness and dimensions of suicide and self-harming behaviours; • Foster participation and communication of messages of purpose and identity to young people.	• Successful completion of the Family Well Being program enabled project officers to facilitate delivery of the Program. • Family Well Being training was delivered over 9 week long workshops including to 16 participants in Dalby. • 104 community events were held, 27 workforce events, and 1 media event was held.
Project: NEXUS: connecting and strengthening Queensland's young people from refugee backgrounds **Organisation:** Queensland Program of Assistance to Survivors of Torture and Trauma **Location:** Toowoomba and Brisbane, QLD	The aims of this project include: • To decrease suicide risk in young people who have attempted suicide or are at high risk of attempting suicide; • To increase the proportion of young people from refugee backgrounds with internal locus of control thereby building resilience; • To improve community attitudes, understanding and awareness to better identify and help young people at risk; • To increase the number and quality of connections of young	• 207 Community Events, 120 Individual Client Services, and 143 Media and Partnership Events throughout the three year period. The external evaluators of the NEXUS Program stated: • The program effectively addresses some of the psychosocial and educational challenges experienced by vulnerable youth, which can seriously increase the risks of suicide and self-harm and is perceived as a valuable preventive program against suicide and self-harm.

	people from refugee backgrounds; • To decrease the impact of high academic and employment expectations on the suicide risk of young people from refugee backgrounds thereby building resilience.	• The program reaches about 15 percent and 34 percent of the youth from refugee backgrounds (12 – 24 years) living in Brisbane and Toowoomba respectively. • As Toowoomba largely lacks the support services for refugee communities that are present in urban areas, the extension of the program to Toowoomba has been strategic, successful in engaging young people, and supported by the community.
Project: Suicide Prevention and Mental Health Support Program **Organisation:** Burdekin Community Association **Location:** Burdekin Shire, QLD	The key aims of this project are: • The establishment of a community–based education and awareness program on suicide prevention in the Burdekin Shire; • The provision of drug abuse awareness and suicide prevention programs through schools and youth groups; • Heightened community awareness amongst mental illness sufferers of local clinical service providers and support groups.	• 198 community members (and 13 team leaders) received training through a 1 day Suicide Intervention Course. • Over 5500 Mental Health Information Packs distributed throughout the community. • 126 community events attended to promote community awareness of issues and many local partnerships developed. • The "Help When You Need It" specially tailored youth program distributed to all high and primary schools within the Burdekin Shire. • 120 individual client services were provided.
Project: Something Better **Organisation:** Queensland Police Citizens Youth Club (PCYC) **Location:** QLD	Queensland Police Citizens Youth Club (PCYC) aims to support youth, improve communities through partnerships and programs, and promote physical, mental and social welfare of Indigenous youth. This project aims: • To provide structured suicide prevention awareness training for Sport & Recreation Officers and relevant PCYC staff; • To provide the client group with exposure to support and advice from qualified professionals trained in youth suicide, in particular, from Queensland Health and Queensland Police; • To provide the client group with access to formal organised sporting and recreational activities.	• A number of Indigenous Coordination Sports & Recreation Officers employed across various communities and involved in suicide prevention training. • All staff have attended the first LIFE workshop delivered by the Edward Koch Foundation. • Focused service delivery within geographically close communities achieved the best outcomes. This enabled a clear focus on ongoing activity continuity for both the youth and the community, particularly in relation to skills offered.
Project: Drop the Rock	This project aims to enhance local and visiting social and mental	• 13 participants completed all modules and graduated with a

Organisation: Royal Flying Doctor Service **Location:** QLD	health services by developing or increasing the capacity of local community counsellors to provide basic counselling, support, and liaison to assist clients experiencing social and emotional wellbeing and mental health difficulties, through: • Developing a training program for community based counsellors that is consistent and integrated with government traineeship schemes; • Identifying and employing one male and one female community person to take up the community counsellor positions; • Developing strategies to ensure ongoing sustainability of the positions.	Certificate IV. • At the time of graduation, 9 of the 12 graduating participants were in paid employment with RFDS as Community Support Workers. • Of the remaining 3 graduating participants; 1 worked as an Indigenous Mental Health Worker with QLD Health and 2 worked as general Health Workers, with a Mental Health portfolio with QLD Health. • 9 of the graduating participants expressed a keen interest to undertake further education.
Project: Living Beyond Suicide: Practical support for those bereaved by suicide **Organisation:** Anglicare South Australia **Location:** South Australia	This project aims to: • Design an early postvention model that provides immediate support to families bereaved through suicide; • Maintain links with key community groups, service providers and referral networks; • Recruit, train and manage volunteers to provide emotional and practical support to families.	• As of April 2009, 49 Family Support Volunteers recruited within Adelaide, Southern Fleurieu and the Riverland. • As of March 2009, it is the only suicide postvention service in SA providing face-to-face time with families in their own homes in the hours and days after a suicide. • The project has engaged with 71 families (over 170 individuals) and over 400 hours in active support.
Project: Sustainable Personal Development for Aboriginal Men **Organisation:** Centacare Catholic Family Services – Port Pirie Diocese **Location:** Port Augusta, South Australia	This project aims to equip Indigenous men aged 15-45 to more effectively manage challenging life situations through culturally appropriate personal development resources and training modules.	• Over 300 community members have participated in awareness raising activities including consultations. • 3 workshops conducted with 18 Aboriginal resource persons trained to facilitate delivery of workshops. • 24 individuals sought support and were referred to appropriate services.
Project: Pathways to Care – Suicide Questions, Answers and Resources (square) **Organisation:** General Practice South Australia **Location:** South Australia	This project will integrate the square suicide prevention resources within General Practice and aims to: • Develop and implement a primary health care suicide prevention model; • Develop supporting resources including tools to assess and manage suicide risk, and referral pathways;	• Implementation has occurred in several regions in SA, in conjunction with drought initiatives in some areas. • A flexible training program forms part of the supporting resource material and this has been delivered to a wide range of both health and non-health professionals.

	• Integrate square suicide prevention resources with other programs involving General Practice eg. Drought, mental health, Aboriginal health.	
Project: Hope, Opportunity, Purpose, Education and Employment or 'H.O.P.E Shared Responsibility Agreement' **Organisation:** Mildura Aboriginal Corporation **Location**: Mildura, Victoria	The purpose of this project is to provide psychological and coordination services to young Aboriginal and Torres Strait Islander students at risk of suicide and self harm in the Mildura area. This project addresses the complex interface between education and anti-social behaviour, and provides opportunities to develop healthy lifestyle behaviours through sport and connection to the Primary Health Care system.	• Individual Life Learning Plans developed for each student involved in the Project and three way reporting carried out by teachers in consultation with students, families and carers. • Eight diversionary programs conducted over the 2008/09 period, covering art, culture and sporting activities. • Suicide First Aid Skills Training workshops held with 13 key stakeholders. • The potential suicide of a client was prevented through intervention and the creation of a "safe plan". The project is continuing to work closely with other service providers to care for this family.
Project: Victorian Building and Construction Industry Life Care Skills **Organisation:** Redundancy Payment Central Fund Ltd (trading as Incolink) **Location:** Victoria	The key objectives of this project are: • To reduce the prevalence of suicide risk among apprentices and young workers in the Building and Construction Industry; • To increase access to information and resources for apprentices and young workers, and training providers of TAFE and Group Training Centres for the industry; • To increase access to support services for those at risk; • To establish and strengthen links between TAFE/Group Training Centres, Building and Construction Industry young workers and apprentices and local community services; • To increase the Life Care skills of the target group.	• Successful development of a Life Care Skills program for raising awareness of suicide risk factors and promoting life care skills in the Victorian Building & Construction Industry. • 221 Life Care Skills sessions run, reaching approximately 3,000 apprentices and young workers. • Additional 2,000 apprentices and young workers participated in informal group sessions at construction and educational sites. • Partnerships developed with 18 regional training centres and numerous community support services. • 193 apprentices and young workers received one-to-one support. • Over 500 Life Care Skills DVDs distributed across industry and community organisations in Australia.
Project: Call Back Services: A risk management strategy for prevention and early intervention	Building upon the Crisis Support Services Suicide Helpline, this project aims to introduce a highly targeted 'call back' service to enhance the capacity of the Helpline to respond effectively to	• Assistance provided to callers with limited support options as a result of geographical, social or other isolating factors. Calls

Organisation: Crisis Support Services Incorporated **Location:** Victoria	the diverse abilities and needs of callers. The key objectives are: • To provide a safety net for callers at risk to ensure that needed support is accessed; • To create a vehicle for monitoring and assessing the effectiveness of information, referral or any other strategy suggested by a counsellor; • To demonstrate and create resources which document practice based evidence of the most effective strategies for supporting families.	received from professionals, people who were suicidal or carers of suicidal individuals from across all states. • Reduced suicide risk for all people accessing the service. • 82% of clients reported being more confident in seeking future help and 97% reported being satisfied with the service. • Links established with acute care providers in each state and 500 service providers including GPs, Mental Health Teams, Royal Flying Doctors and the Standby Response Team. • Database developed to record caller profiles, referrals and outcomes. • Online tool developed to provide information and support to carers and family members.
Project: Support After Suicide (SAS) **Organisation:** Jesuit Social Services **Location:** Victoria	This project aims to support those bereaved by suicide through the following objectives: • To build the capacity of existing health, welfare and education services in metropolitan and rural Victoria to respond effectively and appropriately to people bereaved by suicide; • Further development of information and resources to be available to the bereaved and professionals supporting them; • Provide counselling and groupwork support to suicide bereaved people with a particular emphasis on children, young people and families; • Promote understanding and awareness about suicide and suicide bereavement to the community, professionals and the bereaved.	• Direct support provided to people bereaved by suicide. • Resources, information and advice provided to organisations and individuals e.g. schools, counsellors, police, mental health services, churches and the Coroner's Court. • Partnerships and networks developed. • Counselling and group support provided to people bereaved by suicide in various forms including 8 week group songwriting workshops and an adventure weekend for boys. • Website developed to provide information and resources for the bereaved and professionals who are working with them.
Project: Mental Illness and Bereavement Project **Organisation:** SANE Australia **Location:** Victoria	The key objectives of this project are: • To build an evidence base about improvements to services for relatives and friends of people with mental illness who have suicided or gone missing; • To develop service enhancements that improve the level of	• 41 bereaved family and friends interviewed regarding their needs and experiences. • 50 mental health and bereavement services responded to questionnaires about how they currently support the target group and how their services could be enhanced.

	support provided in the community to the target group; • To enhance the capacity of services to provide new initiatives by staff development and training of staff from SANE and other key organisations in the area; • To implement a series of practical and achievable enhancements to services and supports for family and friends of people with mental illness who have died or gone missing.	• Development and delivery of resources for bereaved family and friends and for mental health including: o factsheets o bereavement guidelines for mental health services o training DVD and education workshops for staff at mental health, bereavement and helpline services around Australia o 16 train-the-trainer workshops provided to approximately 250 staff from 50 services around Australia
Project: OzHelp **Organisation:** The Ozhelp Foundation **Location:** Tasmania	The OzHelp Foundation is a work based suicide prevention, early intervention and social capacity building program which has been implemented in the ACT building and construction industry since 2002. They key objectives of the project are: • Provide pro-active suicide prevention services to the Tasmanian building and construction industry; • Bridge gaps between those at risk and existing professional services; • Work collaboratively with the local and broader community; • Provide early intervention counselling and social capacity building skills; • Provide referral services for complex cases to established service providers.	Outcomes for the 2006-09 period: • Life Skills training conducted with apprentices /trainees. • 3 ASIST courses completed for industry. • Industry worksafe programme SafeTALK implemented. • Workplace program / mentor / supervisory package trialled in 4 organisations. • Media based health promotion activities including a newsletter and print material provided. • Promotion through 5 Industry forums and discussions with the Centre for post-compulsory education and lifelong learning. • Field worker support services established: referral and intake policy, and a counselling support service policy.
Project: OzHelp Expansion Project **Organisation:** Ozhelp Foundation **Location:** ACT	This project is concerned with expanding the ACT OzHelp operations to neighbouring regions; to other similar industries and providing infrastructure and operational support to those states establishing OzHelp programs.	• 11 interviews with nine partner organisations completed in June and July 2008, and covered a range of key utilities industry partners in the ACT, construction industry partners in regional NSW, and support services partners in regional NSW. • Both 'construction industry' partnerships and 'support service' partnerships developed in regional NSW areas, namely Moruya, Nowra and Yass.
Project: Ozhelp Sustainable Workplace Model 2008-2009	The key objectives of this project are: • To develop a model of service delivery for workers in	• Three industries and workplaces identified targeting four types of workers.

Organisation: OzHelp Foundation **Location:** Tasmania	industries other than the building & construction industry; • To develop a sustainable workplace model of training and support for future use; • To implement and pilot the model of service delivery in up to five individual workplaces.	• Life Skills Tool Box Book printed and disseminated to trainees. • Sustainability plans developed for each company/workplace. • Four Life Skills Tool Box training days provided per month. • SafeTALK training sessions conducted. • Five hours of direct client support to apprentices, young workers and employers provided per month.
Project: Community Response to Eliminating Suicide (CORES) capacity building program **Organisation:** Kentish Regional Clinic Inc **Location:** Tasmania. Target communities of West Tamar, Dorset, Kingborough, Huon Valley, and Central Coast.	This project aims to provide community capacity building centred on the prevention and intervention of suicide. Local community members will be trained to be trainers and then deliver the program to their own community.	• Suicide intervention and prevention training sessions were held – 1059 people attended to 31 August 2009. • 57 team leaders trained with further sessions planned in August, September and October 2009. • Three team leaders in each region to be mentored to deliver the one day course to 100-200 people in each region. • Website established to allow the different rural communities to work together and support each other.
Project: Rural Alive & Well 2007 **Organisation:** Southern Midlands Council **Location:** Tasmania	This project aims to build the resilience and capacity of men, their families and the community to react to challenging life experiences with a specific focus on suicide. The project's objectives are: • To provide support and assistance to communities to assist them to respond to crises and to cope or recover after adversity; • To establish structures and networks to assist men, families and communities to deal with suicide; • To provide counselling for men and their families at risk of mental health problems and suicide; • Develop and implement strategies in communities to reduce the stigma associated with mental illness, and suicidal behaviours for men and families seeking help; • To harness the cooperation and good will of key leaders in	• Community meetings/forums held with 15 community groups and consultation with 20 service and community groups, local industry and individuals • Formal Drought Network Tasmania established • Community information leaflet, monthly newsletter, service provider's information pamphlet, and Rural Alive & Well pamphlet developed. • Radio interviews, three monthly publications, website listings and newsletters distributed. • Average of 16 home visits conducted per month. • Effective referral systems established with 12 organisations and referrals made. • Four Mental Health First Aid courses delivered. • Suicide awareness /mental health training provided to 156 Rotary members.

	communities, local community services and support groups to respond to suicide.	• Two applied suicide intervention skills training courses provided in each municipality. • Farm safety and Occupational health and safety course developed.
Project: Building a Trauma, Culture and Rural Mental Health Consortium – Reducing Suicide and Traumatic Aftermath in Culturally Diverse Communities in Tasmania **Organisation:** Migrant Resource Centre (MRC) **Location:** Tasmania	This project focuses on reducing the suicide risk and increasing the capacity to respond to suicide crises within Culturally and Linguistically Diverse (CALD) communities and CALD individuals. The key objectives of the project are: • To build partnerships with key organisations that provide services to CALD groups; • To progress gaining the evidence base data for best practice delivery; • To provide services and support to CALD groups identified as likely to be at increased risk for suicide; • To develop internal strategic responses for suicide prevention within the key partner organisations; • To formulate and conduct training programs; • To develop and pilot a decision tree of assessment that allows for cultural identity changes and symptoms that place one at risk of suicide.	• The formalisation of a consortium between the University Department of Rural Health (UDRH) and the Migrant Resources Centre (MRC) (South), establishment of partnership with Relationships Australia for two African Men's Groups, and development of links with Tasmanian services. • Promotion of the project at a state, national and international level via attendance and presentation at meetings, conferences, and forums as well websites. • Design and delivery of CALD suicide prevention, intervention and postvention training to 53 individuals from Tasmanian service providers. • Provision of services to 34 clients, including individual counselling, advocacy, group counselling and group facilitation. • Cross Cultural Awareness Training provided to key service providers. • Development of a decision tree assessment tool and provided to training recipients.
Project: Real engagement and linking for men in industry (REAL4Mii) **Organisation:** OzHelp Foundation Ltd **Location:** Western Australia	The key objectives of this project are to: • Identify workers who are at risk of suicide or have mental health issues in the building, construction and mining industries in the Pilbara region to facilitate access to support services; • Build support services structures and referral pathways in the Pilbara region for workers at risk of suicide or with mental health issues including Indigenous workers.	• Training sessions provided to apprentices through access to BHP, Rio Tinto and TAFE. • 5 sessions of General Awareness Training in suicide prevention and mental health called 'MATES in construction' delivered to 94 apprentices and 23 supervisors between March and May 09. • Work Life Balance & Time/Stress Management workshop delivered to 39 TAFE students. • Building Personal Resilience training delivered to 14 students.

		• A monthly OzHelp newsletter for the Pilbara region developed. • External evaluation found that OzHelp's approach is consistent with the literature in what is showing to be effective in preventing suicide and reducing self destructive behaviours in communities, and that OzHelp's efforts in linking to community organisations is extremely successful.
Project: Active Response Bereavement Outreach Model (ARBOR) Project **Organisation:** Curtin University of Technology (Ministerial Council for Suicide Prevention) **Location:** Western Australia	ARBOR is a pro-active model of postvention which focuses on early engagement of those bereaved, including Indigenous people, with existing support services. The service works in partnership with existing services including police, coronial counselling, medical and community services. The project aims to trial a postvention service model in a defined geographic area of Perth and to roll out this model in a larger scale implementation.	• Development of a service model which is made up of counselling, peer support with peer support volunteers and bereavement support groups. • Resources developed including the counselling model, the volunteer peer support model and volunteer training program and proposals for an Aboriginal Service Model. • 177 clients had at least one direct contact with ARBOR staff.
Project: Promoting Living Project **Organisation:** Perth Primary Care Network **Location:** Western Australia	The key objectives of the project are to: • Build integrated pathways in the region for people at risk of suicide and their family/carers; • Reduce the risk of suicide and self-harm associated with harmful drug and alcohol use; • Increase early intervention and prevention of suicide.	• Professional Forums held: 29 participants at forum on 20 June 2007; 71 participants and 14 speakers on 11 June 2009. • 13 training sessions held with GPs and Practice Nurses. Accreditation obtained for the program to attract CPD points. • Four community suicide awareness training workshops conducted in conjunction with Lifeline. 58 attendees completed evaluation.
Project: Understanding and Building Resilience in the South West Project **Organisation:** Injury Control Council of WA **Location:** Western Australia	The key objectives of the project are to reduce suicide risk factors by: • Facilitating inter-sectoral collaboration to develop and promote strategies for building community resilience; • Building the capacity of local communities to address service gaps and access existing services; • Developing local strategies to facilitate opportunities for people to connect with their communities;	• Local Working Groups established in each of the identified communities – Bunbury, Busselton, Collie, Bridgetown-Greenbushes, Manjimup and Margaret River. • Identification of at risk groups such as youth, socio-economically disadvantaged, Indigenous people, men and same sex attracted people. • Various community and education activities supported. • 285 attendees at 18 gatekeeper workshops In Narrogin.

	• Building the capacity of communities to recognise and respond appropriately to people at risk of suicide; and • Building community capacity for help seeking by increasing community awareness and knowledge of referral and support services.	• Gay and Lesbian Community Services contracted to conduct 6 'Opening Closets' workshops in each targeted community. • 633 attendees at 45 'A Way Through Information Sessions' and 68 attendees at 6 'Map of Loss' workshops conducted across the community. • 41 people aged 14-58 years attending Aboriginal Camps. • School Development Day at Narrogin Senior High School supported. 45 staff participated in an Aboriginal Cultural and Contemporary Issues Raising Awareness presentation. • Local media used to promote activities - 36 incidents reported.
Project: Whole of Community Aboriginal Specific Suicide Prevention Project **Organisation:** Indigenous Psychological Services **Location:** Western Australia	Through consultation with community members and service providers, this project aims to adapt and deliver a 3-phase suicide intervention forum to the Mowanjum, Mullewa and Laverton Indigenous communities.	• Delivery of 5 Suicide Intervention Forums (2 x Mens, 2 x Women's and 1 Youth) to approximately 100 participants in Mowanjum and Mullewa available (results for Laverton not yet available).
Project: Yiriman Project **Organisation:** Kimberley Aboriginal Law and Culture Centre **Location:** Fitzroy Valley, Western Australia	The purpose of this project is to develop a culturally appropriate suicide prevention program for Indigenous people in the Fitzroy Valley through the achievement of the following objectives: • Undertake cultural activities and trips that build strong relationships, self identity and confidence in young people; • Utilise cultural frameworks and trips to promote suicide prevention activities including community awareness and education; • Build stronger relationships and support mechanisms within family groups for individuals at risk of suicide and self harm; • Foster networks and working relationships with community groups, service providers and government agencies with a focus on mental health and alcohol and drug issues; • Undertake a positive town-based activity that relates to young people's interests, promoting strong positive messages and role models in a safe, healthy space.	• Liaison with North West Mental Health, Department of Corrective Services, Department of Child Protection, North West Mental Health, headspace Kimberley and Nindilingarri Drug Alcohol & Mental Health Unit. • 4 bush trips with approximately 97 Aboriginal youth attending - bush trips are community owned and focussed on building supports and strong relationships between young males and the family members, elders and community members (including mentors and supervisors). • Indigenous Hip Hop dance workshop held during the Garnduwa Festival with approximately 33 participants (boys and girls aged 7-15 years old). Workshop covered topics on drug and alcohol, teamwork, self respect, self confidence and leadership.

Project: Suicide Prevention Australia **Organisation:** Suicide Prevention Australia **Location:** National	Suicide Prevention Australia (SPA) is a non-profit, non-government organisation working as a public health advocate in suicide prevention. The aim of the Project is for Suicide Prevention Australia to provide national advocacy for suicide and self-harm prevention, intervention and postvention. Recent objectives include: • Develop position statements and policy on key social agendas and emerging issues and in response to government and public discourse. • Provision of leadership on national issues and providing quality policy advice to government and other relevant organisations. • Conduit for information exchange between the government and SPA's constituents. • Build new and consolidate existing coalitions / relations with organisations with direct interest in suicide prevention. • Conduct key national events to facilitate sector collaboration, diffusion of innovation and tackle key challenges for the sector. • Ensure broad distribution and accessibility of information to SPA members and the broader community on suicide prevention issues.	• Development of position statements on key policy areas. Recent papers include: mental health and suicide, suicide bereavement and postvention, suicide and self-harm amongst gay, lesbian, bisexual and transgender communities and supporting suicide attempt survivors. • Distribution of position statements to a range of stakeholders as well as uploading of the statements on the SPA website and referred to in the SPA quarterly e-newsletter. • Coordination and facilitation of the National Committee on Standardised reporting of Suicide. • SPA to co-host the 4th Asia-Pacific International Association of Suicide Prevention (IASP) Regional Conference in 2010 with the Australian Institute of Suicide Research and Prevention (AISRAP). • Coordination of activity in conjunction with World Suicide Prevention Day - including the LIFE Awards, and the SPA World Suicide Prevention Day Community Forum. • Establishment and consolidation of relationships with state and national NGOs, private organisations and government service providers. • Active participation in joint forums, campaigns, and advocacy meetings.
Project: Access to Allied Psychological Services (ATAPS) Additional Support for Patients at Risk of Suicide and Self-Harm Project **Organisation**: 18 Divisions of General Practice across Australia; Crisis Support Services Inc; and the Australian Psychological Society	This project provides support for people who have presented to a GP or a hospital accident and emergency department having self-harmed, attempted suicide or demonstrated suicidal ideation. Referral pathways are created to specialised allied psychological services, ensuring that patients are contacted by an allied health professional within 24 hours of discharge from the hospital or contact with a GP. The project is being trialled in 18 demonstration sites around Australia.	During the period 1 January 2009 – 30 June 2009, a total of 462 referrals were made and 2321 trial sessions were delivered across the 18 Divisions of General Practice. Uptake varied widely across Divisions. The support services provided by Crisis Support Services have resulted in 99 calls with clients to September 2009.

Location: National	Funding is also provided to Crisis Support Services to provide 24 hour telephone support to: • ensure immediate follow-up after referral out of hours; • provide after hours follow up calls to clients at extreme risk; • provide 24 hour crisis support for clients. The Australian Psychological Society is funded to provide suicide prevention specific training and professional development to allied health professionals participating in the program.	
Project: Access to Allied Psychological Services (ATAPS) Bushfire Support Project **Organisation**: 6 Divisions of General Practice in Victoria	Funding was provided to six Divisions of General Practice in the areas most greatly affected by the Victorian bushfires in 2009 to provide post-disaster support to those members of the community that are at risk of self harm and/or suicide.	Building upon the ATAPS model, the funding boosts the capacity of Divisions to offer appropriate expertise to identify, support and protect individuals at heightened risk of suicide or self harm as a result of the bushfire disaster.
Project: Case Control Studies of Suicide and Attempted Suicide **Organisation:** University of Sydney **Location:** NSW	This project will undertake three cases-control studies of suicide and attempted suicide in young adults in New South Wales. The overall research project aims to: • quantify individual risk factors in combination with socio-demographic factors as contributors to suicide and attempted suicide; and • establish relationships between suicide and attempted suicide risk factors as they occur as background to and precipitants of suicide events.	The outcomes of this project are expected to be provided to the Australian Government in January 2010.
Project: The Peer Support Program **Organisation**: Peer Support Australia **Location**: National	The Peer Support Program is a school-based promotion and prevention program targeting children and young people. The Program aims to enhance resilience and resourcefulness, respect, interconnectedness and mental health in young people, families and communities, and reduce the prevalence of risk factors for suicide. The Program is aligned with national frameworks including the National Safe Schools Framework (NSSF), National Framework	• The Program operates in over 1,400 schools in NSW, ACT, Queensland, Tasmania, Western Australia and the Northern Territory. • A longitudinal study involving 2,300 secondary students across NSW indicated that the Peer Support Program: o assists students to successfully negotiate transition from primary to secondary school; o improves relationships with others - peers and teachers; and

	for Values Education, MindMatters, KidsMatter and NCAB.	o successfully changes attitudes toward bullying behaviours.
Project: The Lifeforce Community Networks Project **Organisation:** Wesley Mission **Location:** National	This project aims to educate, empower and resource Australian communities to be aware of the issue of suicide, to recognise the signals of suicide and to be sufficiently resourced to refer individuals with thoughts of suicide to appropriate and qualified help. Expected outcomes for communities in which LifeForce components are developed and implemented include: • increased knowledge and awareness for gatekeepers and the broader community, • increased help seeking behaviours and support for family and friends after a suicide; • the development of local suicide prevention plans through greater networking, community liaison and collaboration amongst key stakeholders and the wider community; and • gatekeeper learning program achieve consistent improvement in the confidence and knowledge of participants.	• Identification and establishment of suicide prevention networks in all states and territories across Australia. • The delivery of suicide prevention workshops, forums and events to raise awareness of the issues surrounding suicide and measures communities can take to address them. • The continuous development of learning programs which focus upon awareness raising, challenging attitudes, and teaching basic engagement and intervention skills. • The delivery of memorial days in selected areas across Australia.
Project: Youth Mental Health First Aid Program **Organisation:** Orygen Research Centre **Location:** National	This project aims to develop a course specifically dealing with the mental health problems of adolescents to be known as the Youth Mental Health First Aid Program (YMHFA). The course will cover how to give initial help for the following disorders: depression, anxiety, psychosis, eating, and substance use. It also covers first aid in a number of crisis situations: suicidality, deliberate self-harm, panic attack, traumatic experience, out of contact with reality and perceived to be threatening, and substance overdose.	• 15 Instructor Training courses; nine 3-day courses and six 5.5 day courses conducted. • 216 instructors completed the 14-hour Instructor Training course. 192 completed detailed feedback forms Feedback on the delivery which indicated that: o Of the 192, only one rated themselves as unprepared; o 25% rated themselves very well prepared; o 55% rated themselves well prepared; and o 19% rated themselves somewhat prepared. • Scholarships valued at $2000 were distributed and well received, particular by instructors in regional and remote areas. • Feedback has consistently improved over time. • 224 participants completed 17 free courses in Victoria delivered for various community groups including Scouts, Red

		Cross, sports clubs, neighbourhood houses, local government and youth studies students. • Instructors have run 376 14-hour courses to a total of 5,224 participants, in every state and territory of Australia.
Project: Reach Out! **Organisation:** The Inspire Foundation **Location:** National	Reach Out! is a web-based service that inspires young people to help themselves through tough times. The key objectives of this project are to: • Develop a website for professionals to provide information, updates, best practice case studies (to be developed with community consultation participants), and interactive content to facilitate the engagement of young people in both the treatment and maintenance of better mental health outcomes, including a reduction in suicidal behaviour, depression, drug and alcohol use. • Promote the resource to local health service providers and community agencies working with young people via leaflet distribution, media coverage, conferences; and • Increase help-seeking among young people aged 16-25.	• The Reach Out User Profiling Survey conducted from July to September 2008 attracted 1006 participants, of which 904 were young people and 102 were professionals. • Highlights of the results from professionals were: - Professionals are highly likely to recommend Reach Out to young people and colleagues - 92% rate the Reach Out website as very good or excellent - 84% of participants were repeat visitors to Reach Out - Professionals are using Reach Out more regularly with 51% using it fortnightly (up from 41% from the 2007 survey) • Highlights of the results from young people are: - 60% are in Reach Out's target age range of 16-25 - 24% visit Reach Out at least once a week; the average frequency is once a month - The main reason young people visit Reach Out is because they are going through a tough time and the main type of information they are looking for is about mental health issues - Young people report that Reach Out helps them learn more about mental health issues (82%), understand other people's experiences of mental health issues (77%) and learn where to get help with mental health issues (74%) - Reach Out contributes to increased help seeking with 59% of repeat visitors talking to a professional after visiting Reach Out - 81% would tell a friend about Reach Out

Project: Mindframe Education and Training Projects **Organisation:** Hunter Institute of Mental Health **Location:** National	As a component of the Mindframe Initiative, the aim of the Mindframe Education and Training Projects is to enhance the media's capacity to report responsibly, sensitively and accurately on issues relating to suicide and mental health/illness. The Hunter Institute manage a number of projects which have focussed on providing resources and education opportunities for media professionals, facilitating the inclusion of these issues in tertiary journalism education, the mental health and suicide prevention sector, police and courts, and those involved in the development of Australian film, television and theatre. These are: • ResponseAbility Journalism and Public Relations Project; • Mindframe Media and Mental Health Project • Mindframe for the Mental Health & Suicide Prevention Sector Project; • Mindframe Stage and Screen Project; and • Mindframe Police and Courts Project.	The key outcomes/achievements for the period 2006-09 were: ResponseAbility Journalism & PR • Delivery of 60 guest lectures and tutorials and dissemination of a further 72 resource kits; • Development and dissemination of additional resources for journalism educators; • Launch of Academic Research Scheme; • Evaluation outcomes indicate 100% awareness and uptake of the journalism resources among university campuses • More than 126,000 visits to website between October 2008 and April 2009 Mindframe Media & Mental Health Project • 134 additional briefings in each state and territory engaging over 500 journalists and editors; • Successful complaints lodged with ACMA about suicide reporting and the APC about reporting of mental illness; • Involvement in 21 media conferences; • More than 130,000 visits to website between November 2008 to April 2009. Mental Health & Suicide Prevention Sector Project • Dissemination of over 1,100 copies of resource and 4,500 copies of quick reference card; • Development and delivery of 45 interactive workshops engaging over 530 participants; • Development of Mindframe Capacity Building Model and Pilot; • Pilot demonstrated improvements in capacity across several dimensions and an overwhelming support for Mindframe and the capacity building model. Stage and Screen Project • More than 22,000 website visits from November 08 to May 09; • Development of workshop formats to promote to television

		series and serials; • Workshops delivered to Screenwriters and scriptwriters; • 2,788 resource books disseminated nationally since 2007. Police and Courts Project • National Scoping Study with recommendations for future work; • Development of resources based on consultations with sector; • More than 1,360 resource books disseminated to judicial sector since development, and over 3,000 to police. • From January 2009, website views have remained consistently above 1200 views per month for both police and courts sections.
Project: LIFE Communications **Organisation:** Crisis Support Services Inc **Location:** National	This project provides national strategic suicide prevention communications and provides stakeholders with: • Access to the 'Living Is For Everyone' suite of resources; • Access to the latest information, activities and resources in suicide prevention; • A vehicle to contribute their learnings and draw on each other's expertise; and • Facilitation of clear and effective communication channels across a broad range of suicide prevention stakeholders in Australia.	• From June 2009 to September 2009, 674 hard copies of the LIFE Resources were distributed, the majority through the attendance at conferences by the project team, and through orders from the LIFE website. • From June to October 2009 there were over 16,300 visits to the LIFE website, 88% of which were within Australia. • From June 2009 to September 2009 over 1100 copies of the LIFE Framework were downloaded from the website, 1797 of Research and Evidence Document, and the full set of fact sheets was downloaded 541 time
Project: Community Radio Suicide Prevention Project **Organisation:** Community Broadcasting Association Australia **Location:** National	This project aims to provide help-seeking and wellbeing messages to a wide and diverse network of communities nationally reaching a large number of Indigenous communities, rural and remote, and culturally and linguistically diverse communities. This project utilises both satellite and local radio broadcasting to provide 24 hour a day national delivery of suicide, mental health and well-being messages.	• Messages reach over 9.5 million people in an average month through over 270 radio stations around Australia. • 94% of stations have actively discussed the issues and services profiled in the audio segments with their local audience. • 81% of stations have received positive feedback from their local community regarding the messages. • 79% of stations have reported phone calls from listeners to

		request phone numbers or other information after hearing project audio on air.
Project: SANE Media Centre and Stigmawatch **Organisation:** SANE Australia **Location:** National	This project aims to promote accurate, respectful and sensitive depiction of mental illness and suicide by exposing cases of media stigma to public scrutiny and educating those responsible to change their practices.	• Support provided to mental health organisations that do not have media/communications staff throughout Australia. • 107 people in the mental health sector contacted the project for support. • 369 enquiries received from the media about mental health and suicide. • Regular contact from 14 scriptwriters and producers for advice and information, plotlines and character development. • Actioned 128 stigma reports with 21 media professionals seeking ongoing liaison.
Project: StandBy Suicide Bereavement Support Service **Organisations: :** United Synergies Ltd, Lifeline Community Care Queensland, Support Link Ltd, Anglicare WA Inc, Pilbara Division of **Location:** National: ACT, Brisbane, Sunshine Coast, Caloola, Western Australia, Tasmania	The StandBy Service provides an integrated, comprehensive, responsive support system built on existing emergency and community response mechanisms for people at risk of suicide and self harm, their family, friends, associates and those affected by suicide bereavement.	• A two year independent evaluation of the Canberra, Brisbane and Sunshine Coast/Cooloola sites found that StandBy increased community capacity to respond effectively, reduced suicidal ideation, improved 'normalising' the grief experience including the ability to live with the loss of a loved one by suicide. • Four additional sites have been established in Hobart, Launceston, and the Kimberly and Pilbara regions.
Project: Redevelopment of the Bereavement Support Pack **Organisation:** Urbis Keys Young **Location:** National	This project aims to redevelop the content and design of the 'Information and Support Pack for those bereaved by suicide and other sudden death' based on the outcomes of the National Activities on Suicide Bereavement Project and involves consultation with state and territory authorities and organisations.	The redevelopment is complete following extensive consultation and is to be printed and available nationally in the near future.
Project: National Centre of Excellence in Suicide Prevention	The purpose of this project is to: • provide advice to the Australian Government and other	• Advice has been regularly provided to the Department and the Australian Suicide Prevention Advisory Council regarding

Organisation: AISRAP, Griffith University **Location**: National	agencies regarding best practice in suicide prevention; • offer direct support to agencies contracted by the Department; • provide a bi-annual critical literature review regarding suicide and suicide prevention; • provide advice on improving evaluation of suicide prevention work; and • provide advice on the quality of suicide data.	suicide hotspots and access to mean, the impact of the economic recession on suicide, Indigenous suicide and men's issues. • The Centre published its first bi-annual literature review on 11 May 2009. • Evaluation advice has been provided to a range of projects. • The Centre is currently conducting a mapping exercise of existing national suicide prevention programs to identify gaps/linkages in services.
Project: Australian National Epidemiological Study of Self Harm **Organisation:** The University of Queensland **Location:** National	This project undertook research relating to deliberate self harm over a 4 week period analysing methods, history, frequency, help seeking, and outcomes in relation to suicide and suicidality.	The study showed: • the prevalence of self injury in the Australian population as 1.1% (231,000 people); • 83% of people self injuring did not receive medical attention; • self injury is strongly associated with suicidal ideation; • the estimated cost of hospitalisation is $24.7M over the 4 week period.
Project: WHO START Project **Organisation:** AISRAP, Griffith University **Location:** National	This project aims to investigate preventative interventions across various countries, cultures and population sub-groups with the Asia-Pacific region.	The project is due to report in May 2010.
Project: Living Hope Conference 2009 **Organisation:** Salvation Army **Location**: National	This Project aims to provide information, support and networking opportunities for collaboration between postvention researchers, practitioners and those bereaved by suicide.	• 235 people attended the Conference. • 58% of attendees had been bereaved by suicide. • 60% of attendees represented an organisation working with those bereaved by suicide. • 41% of attendees completed the Conference survey and the findings were that: o 67% of respondents felt that the conference was very to extremely valuable. o 20% felt that the conference was moderately valuable. o 13% felt that the conference was of little or no value.
Project: The Mindmatters Initiative	The Mindmatters Initiative is the national mental health	• The MindMatters Initiative is provided in 3,000 Australian

Organisation: Principals Australia **Location**: National	promotion, prevention and early intervention initiative for Australian secondary schools and has the goals of: • enhancing the development of school environments where young people feel safe, valued, engaged and purposeful; • developing the social and emotional skills required to meet life's challenges; • helping school communities create a climate of positive mental health and wellbeing; • developing strategies to enable a continuum of support for students with additional needs in relation to mental health and wellbeing; and • enabling schools to better collaborate with families and the health sector.	secondary schools. • Provision of hardcopy materials to every secondary school in Australia, a website, and delivery of professional development to teachers and other school personnel on an opt-in basis. • Provision of resources including background information for schools, planning tools, activities for classroom use on various mental health topics and links to a list of programs and internet sites that contain reliable information and health support networks.
Project: Hope for Life **Organisation:** The Salvation Army **Location:** National	The Hope for Life suicide bereavement support service includes a website, online and face to face suicide prevention gatekeeper training and a resource kit for frontline Salvation Army staff.	• The website has had over 10,000 visitors • 100 people have completed gatekeeper training • Almost 500 people have completed the online training course

APPENDIX E. Membership and Terms of Reference for the Australian Suicide Prevention Advisory Council

- **Australian Suicide Prevention Advisory Council Members**

Professor Ian Webster (Chair)
Emeritus Professor of Public Health and Community Medicine, University of NSW; Chair of the former National Advisory Council on Suicide Prevention

Ms Dawn O'Neil
Chief Executive Officer of Lifeline Australia; Deputy Chair of the Mental Health Council of Australia

Dr Michael Dudley
Chair of Suicide Prevention Australia; Senior Staff Specialist in Psychiatry at Prince of Wales and Sydney Children's Hospitals

Ms Wendy Sturgess
Former Chief Executive Officer of Crisis Support Services

Professor Diego de Leo
Director of the Australian Institute for Suicide Research and Prevention, Griffith University; Professor of Psychopathology and Suicidology

Professor Brian Kelly
Professor of Psychiatry, Newcastle University; Consultant Psychiatrist in rural NSW

Ms Barbara Hocking
Executive Director of SANE Australia

Ms Janet Meagher
Director of Development for the Psychiatric Rehabilitation Association; Representative of the Consumers' Health Forum of Australia

Ms Adele Cox
Chair of the National Indigenous Youth Movement of Australia; Academic at the Centre for Aboriginal Medical and Dental Health, University of Western Australia

Associate Professor David Ranson
Deputy Director of the Victorian Institute of Forensic Medicine; Past Director of the National Coronial Information System

- **Terms of Reference for the Australian Suicide Prevention Advisory Council**

  The objective of the Australian Suicide Prevention Advisory Council is to provide confidential advice to the Australian Government through the Minister for Health and Ageing on strategic directions and priorities in relation to suicide prevention and self-harm in order to support the Australian Government's implementation of the National Suicide Prevention Strategy (NSPS).

  The Council will provide a forum for expert service providers, researchers and clinicians to share expertise, to input into the decision-making processes and to identify community needs and priorities for the NSPS that would be informed by the best available evidence.

  The Council is an advisory body to Government. It is not a decision-making body and has no legislative basis.

  Roles and Functions

  1. Provide advice to the Australian Government on:
     - existing and emerging evidence for suicide prevention strategies;
     - national priorities and requirements for suicide prevention activities under the NSPS;
     - population-based approaches, as well as approaches to target the needs of high risk groups;
     - the development, periodic review, update and dissemination of resources and communication materials to support the NSPS, such as the Living Is For Everyone (LIFE) Framework resources; and
     - best approaches to implementation of Commonwealth funded suicide prevention activities, including coordination and integration with state and territory activities.

  2. Advise on approaches to measurement of the progress and effectiveness of the NSPS.

  3. Facilitate linkages and relationships with other relevant committees and government programs, including the National Advisory Committee on Mental Health (NACMH) and the Mental Health Standing Committee.

Deliverables
At each meeting and as requested by the Minister, the Council is to respond to requests for advice on emerging issues. This will be coordinated through the Secretariat.

Timeframes
It is anticipated that there will be three face to face meetings of the Council per year with additional teleconferences and working group meetings as required to progress specific issues.

The Council will have fixed terms and be reviewed after a three year period. Continuation of the Council will be at the discretion of the Minister for Health and Ageing.

Reporting
The Council will provide a written report to the Minister for Health and Ageing on an annual basis.

Membership of the Council
Council members will be appointed by the Minister for Health and Ageing. The membership of the Council will consist of up to 20 individuals with particular expertise in suicide, including clinical, consumer, government, community, academic and professional perspectives.

Remuneration and Travel Expenses
Members of the Council will be remunerated in accordance with Category 1 rates set by the Remuneration Tribunal. Travel arrangements and expenses will also be met by the Department and members will be paid a Tier 3 travel allowance.

Conflict of Interest and Confidentiality
Members of the Council will be required to sign a 'Conflict of Interest' form. Conflict of interest is defined as any instance where a Council member has a direct financial or other interest which influences, or may appear to influence, proper consideration within the Council on a matter or proposed matter.

Secretariat/Contact
The Department of Health and Ageing will provide secretariat support to the Council.

APPENDIX F. Mindframe Media and the Media Monitoring Report

Mindframe Media & Mental Health

The Mindframe Media and Mental Health Project aims to work collaboratively with the Australian media and mental health system to enable more accurate and sensitive reporting of suicide and mental health issues The project promotes and disseminates resources for media professionals, including the resource *Reporting Suicide and Mental Illness* for use by media professionals, and works with peak media bodies to improve existing codes of practice.

Mindframe for the Mental Health Sector

The key output from this project is the resource booklet *Suicide and Mental Illness in the Media: A Mindframe resource for the mental health sector*. The resource booklet and companion website were created to assist people involved in the mental health and suicide prevention sectors to communicate effectively with the media about suicide, mental health and mental illness, and to provide information about how the media works and facts and statistics about suicide and mental illness.

Mindframe in the Law Enforcement Sector

This initiative recognises that the courts, police and emergency services are important sources of information for most media organisations. In 2008 new resources for Police and Courts were developed to provide advice about the ways in which they work with or interact with the media on stories that may involve suicide or mental illness. This includes *Mental Illness and Suicide in the Media: A Mindframe Resource for Courts* and *Mental Illness and Suicide in the Media: A Mindframe Resource for Police*.

Mindframe Stage and Screen

The resource booklet *Mental Illness and Suicide: A Mindframe Resource for Stage and Screen* and its companion website were developed through this project to provide practical advice and information to support the work of scriptwriters and others involved in the development of Australian film, television and theatre. The resources are designed to help inform truthful and authentic portrayals of mental illness and suicide and provide information about audience impact as well as comprehensive facts and information on mental illness and suicide.

Response Ability Journalism

The Response Ability project provides a toolkit for lecturers to introduce graduates in journalism and communications to the professional and ethical issues involved in reporting on mental illness, mental health care, and suicide.

StigmaWatch and the SANE Media Centre

SANE Australia's Media Centre and web based StigmaWatch program were established to promote accurate, responsible and sensitive portrayal of mental illness and suicide – encouraging wider public scrutiny of media stigma and promoting progressive reporting.

The programs expose cases of media stigma to public scrutiny and aim to educate those responsible to change their practices and provide accurate information, access and referral to reliable interviewees, 'media-savvy' advice and support, and active promotion of the Mindframe Initiative and its resources.

Table 26: Summary of Media Monitoring Project Report[19]

Area	Findings
Overall volume and quality of articles	▪ Across all media, both suicide and mental health/illness items increased in volume by approximately two-and-a-half-fold from 17,151 in 2000/2001 to 42,013 in 2006/2007. ▪ The number of radio and newspaper items were about equal, and far outnumbered television items – 46.8% newspaper, 6.9% television, and 46.3% radio items were recorded. ▪ In the scale of quality, suicide items increased from 57% to 75%, and mental health/illness items increased from 75% to 80%.
Method and location of suicide	▪ The method of self-harm was described in 14% of media reports, down from 50% in 2001. Additional work has been conducted during the intervening years to create or improve formal industry codes that recommend journalists avoid describing the method of suicide. ▪ 4% of items included a photo, diagram or footage depicting the scene, location or method of suicide.
Language	▪ Only 6.1% of items on suicide used inappropriate language to suggest that completed suicide was a desirable outcome, using terms such as 'failed suicide attempt', 'successful suicide bid'. This figure is down from 41.7% in 2001. ▪ 5.8% of media reports on mental illness used language that was inappropriate, negative or outdated, compared to one fifth of items in 2001. Terms deemed to be inappropriate included 'cracked up', 'crazy lunatics', 'nutcase', 'a psycho', and 'lunatic asylum'.
Stigmatising mental illness	▪ The majority of items on mental illness did not stereotype people affected as violent, unpredictable, unable to work, weak, untrustworthy or unlikely to get better. However, 10.6% of items did stigmatise mental illness in 2006 compared to the previous rate of 14.3%. ▪ The majority of items did not suggest that all mental illnesses are the same. However, 3.4% of stories suggested that all people with mental illness are alike or share the same experiences, down from 16.6% in 2001.
Headlines and story placement	▪ 22.9% of media reports on suicide were placed on the front page or as the leading item, an increase from 16.9% in 2001. ▪ Items that used the word 'suicide' in the headline have decreased from 29.5% in 2001 to 21.2% in 2007. ▪ 8.2% of stories on mental illness had headlines that were

Area	Findings
	inaccurate or inconsistent with the story, compared to 4.2% in the previous study. ▪ Only 6.8% of headlines were found to be unnecessarily dramatic or sensationalised, compared to 29.3% of headlines in 2001.
Celebrity suicide	▪ During the study period, there were a higher number of stories that referred to a person's celebrity status than in 2001, where 13.7% of stories made reference to the person as a celebrity.
Placing suicide in context	▪ Around one quarter of items in 2007 reinforced that suicide is related to mental disorder and other risk factors rather than merely a social phenomenon. This figure has halved from 2001.
Help services	▪ 17.7% of suicide reports and 19.8% of mental illness stories provided information on help services available. Often this was only a brief mention rather than a description of treatment and support options available to people. However, this is a significant increase from the 6.5% of suicide reports and 6.6% of mental illness stories that added information about help services in 2001.