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Dear Committee Secretary

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

The South Australian Government welcomes the Inquiry and I am pleased to provide the attached submission.

I would be happy to provide any additional information to assist the Committee if required.

Yours sincerely

Jane Lomax-Smith MP
**MINISTER FOR MENTAL HEALTH AND SUBSTANCE ABUSE**

07 / 12 / 2009

Encl.

# SUBMISSION TO THE AUSTRALIAN SENATE COMMUNITY AFFAIRS REFERENCES COMMITTEE

# INQUIRY INTO SUICIDE IN AUSTRALIA

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GOVERNMENT OF SOUTH AUSTRALIA

October 2009

## Terms of Reference

The impact of suicide on the Australian community including high risk groups such as Indigenous youth and rural communities, with particular reference to:

1. The personal, social and financial costs of suicide in Australia;
2. The accuracy of suicide reporting in Australia, factors that may impede accurate identification and recording of possible suicides (and the consequences of any under-reporting on understanding risk factors and providing services to those at risk);
3. The appropriate role and effectiveness of agencies, such as police, emergency departments, law enforcement and general health services in assisting people at risk of suicide;
4. The effectiveness, to date, of public awareness programs and their relative success in providing information, encouraging help-seeking and enhancing public discussion of suicide;
5. The efficacy of suicide prevention training and support for front-line health and community workers providing services to people at risk;
6. The role of targeted programs and services that address the particular circumstances of high-risk groups;
7. The adequacy of the current program of research into suicide and suicide prevention, and the manner in which findings are disseminated to practitioners and incorporated into government policy; and
8. The effectiveness of the National Suicide Prevention Strategy in achieving its aims and objectives, and any barriers to its progress.

## Introduction

The SA Health Strategic Health Plan 2008-2010 outlines the four key strategic directions of SA Health within the overarching context of South Australia's Strategic Plan (SASP):

1. strengthening primary health care;
2. enhancing hospital care;
3. reforming mental health care;
4. improving the health of Aboriginal people.

All four strategic directions support the wellbeing of South Australians and are relevant to this submission to the Australian Senate Community Affairs References Committee – Inquiry into Suicide in Australia.

SA Health are committed to a health system that produces positive health outcomes by focussing on health promotion, illness prevention and early intervention. Our objectives, broad strategies and performance measures are set out in each strategic direction.

The South Australia's Strategic Plan target T2.7 Psychological Wellbeing, seeks to ensure that South Australia has an equal or lower level of psychological distress than the Australian average. The Psychological Wellbeing target measures the proportion of the South Australian population aged 18 years and over, who have high or very high levels of psychological distress as measured by the Kessler Psychological Distress 10-item Scale (K10). The baseline rate of high/very high distress in 2001 in the South Australian population was 13.6 percent compared to the national rate of 12.3 percent per 100,000 (2001 ABS National Health Survey data). The current rate for SA is 12.9 percent compared to the national average of 12.0 percent (2007-08 ABS NHS data). These data show that the level of psychological distress in South Australia was slightly higher than both the 2001 baseline Australian average and the current Australian average, however, this difference is not considered statistically significant. The limited size of the South Australian sample results in large confidence intervals around the figure, which could therefore be lower than the Australian average.

The tragedy of suicide is rarely the result of a single cause. A person's decision to take their own life follows the accumulation of and interaction between numbers of associated factors. Risk factors (including violence, substance use and social isolation) that can lead to psychological distress and protective factors (social connectedness, increased resilience and resourcefulness) that promote psychological wellbeing often fall outside of the health and mental health system. These complex and multiple causal factors mean that capacity to identify, influence and affect these factors is not the sole responsibility of one agency, government department or discipline.

SA Health are committed to working with other government agencies and the community to address the environmental, socioeconomic, biological and behavioural determinates of health and to achieve equitable health outcomes for all South Australians. Therefore other SASP targets including unemployment, work-life balance and homelessness will impact on psychological wellbeing.

Mental disorders that impact currently on the Australian population include anxiety, alcohol abuse, personality disorder and depression and the reform of mental health care in South Australia is a key strategic direction. The SA Health Strategic Direction that supports people with a mental illness identified as at higher risk of suicide in the community is *Reforming mental health care* and involves:

- *Provision of integrated services to mental health clients in the community, residential and hospital settings*
- *Improve access to appropriate care at an early stage*
- *Improve mental health services through better systems of care*
- *Improve inter-agency coordination of service delivery to people with a mental illness who have high needs*
- *Increase community understanding of mental health.*

The population health approach to mental health recognises the complex interplay of social, economic, environmental, physical and cultural factors that impact on individuals across the population. SA Health will take a health continuum approach to promoting psychological wellbeing with strategies that promote the maintenance of health and wellbeing in people who are currently not at risk of mental illness, and as well as strategies that assist those who are at risk of, or are already experiencing, a mental illness through recovery.

The *Stepping Up*: A Social Inclusion Action Plan for Mental Health Reform (2007-2012) prepared by the South Australian Social Inclusion Board, provides strategies to promote positive mental health in the community. This report lays out a detailed five-year action plan to reform the mental health system in South Australia and to provide better, more responsive services and an integrated system of care. These strategies involve increasing mental health literacy particularly regarding depression through the South Australian Government partnership with *beyondblue*, and the introduction of a *stepped model of care* which will be supported by appropriate new service models and new facilities in a community environment. These new service models assist people with complex and chronic mental illnesses, increasing community based facilities, new psychosocial support services delivered through non-government organisations and a better mental health aged care service model. Considerable progress has been made in the reform of mental health services in South Australia are summarised and presented in Appendix 1 of this submission.

## Key Messages

Suicide is a matter of considerable public concern and policy significance. The South Australian Government welcomes the opportunity to provide information and comment to the Senate Community Affairs References Committee Inquiry into Suicide in Australia.

The key messages that the Government of South Australia would like the Senate Community Affairs References Committee to note are:

1. Issues with the quality of suicide data generated need to be addressed to increase the accuracy and reliability of ABS reporting and comparability of these data across jurisdictions.
2. The complex and multiple causal factors leading to suicide suggest that the capacity to identify, influence and affect these factors is not the sole responsibility of one agency, government department or discipline. A collaborative approach to suicide prevention and awareness is needed.
3. The South Australian Government funds a range of programs targeting suicide prevention and awareness in the community and training for front line health and community workers.
4. The South Australian Government, through SA Health, is developing a Statewide Suicide Strategy that will focus on social justice, coordination, collaboration, partnerships and building on existing programs.
5. There are opportunities to create national frameworks and standards for targeted programs given similarities across jurisdictions within particular at risk groups.
6. Greater research and evaluation into the efficacy of programs and interventions will allow policy makers, service planners and providers to refine suicide prevention plans and strategies, target them more effectively and achieve better outcomes in the community.

# ADDRESSING THE TERMS OF REFERENCE:

## 1. The personal, social and financial costs of suicide in Australia

### 1.1 The costs of suicide

Every suicide has a significant impact on the surviving family members, friends and the community of the deceased. The trauma of failed suicide attempts and the costs associated with emergency medical treatment as well as impairment to health and functioning as a result are also important to consider. Quantifying these costs requires further research.

### 1.2 The extent of youth suicide

Suicide has a significant impact on children and young people through the loss of potential, development and capacity. Research and a review of the literature by SA Health's Children, Youth and Women's Health Service (CYWHS) indicates that suicide in adolescents under the age of 16 years remains rare, and there has been no demonstrable increase in numbers over the time of the study (1997-2005).

Examination of the South Australian coroner's records in the study period revealed 21 deaths by suicide in children and youth under the age of 16 years. This rate represents approximately two to three suicides per year despite a likely increase in population over this period.

A similar study by Byard et al (2000)[1] examined the files of the South Australian Forensic Science Centre for the years 1985-1997. Over this 13 year period, there were 48 cases of youth suicide under the age of 17 years. This represents an absolute rate of three to four suicides per year, which is slightly higher, given the older age cohort. Males comprise around 80 percent of this group and hanging is the most likely method.

Suicide is the leading cause of violent death in Australia. However the rate of male suicide per 100,000 population has changed little in 100 years, from 20.6 in 1897 to 21 in 1995 (Byard et al, 2000). There has been a marked change in the age distribution of suicides. A decline in deaths over the age of 65 years has been counterbalanced by a four fold increase in numbers of suicide between 15 and 25 years of age over the past three to four decades.

The evidence presented by Byard et al (2000) suggests that suicides in youth under 16 years of age in South Australia is a very rare event and has not changed significantly in the past 20 years. It represents only two percent of total suicides in South Australia over this period. Patterns of mortality in young adults show young Australians aged 20 to 24 years are roughly four times more likely to die than an adolescent or younger child.

The leading causes of death for people aged 18 to 24 years are traffic accidents (30 percent) and suicides (19 percent). The Aboriginal and Torres Strait Islander population has a suicide rate six times higher than other young Australians. According to an AIHW report on

[1] R.Byard, D.Markopoulos, D.Prasad, D.Eitzen, R.James, B.Blackbourne, H.Krous (2000) Early adolescent suicide: a comparative study; *Journal of Clinical Forensic Medicine*, volume 7, Issue 1, Page 6-9

the wellbeing of young Australians, suicides in young people have decreased by 35 percent in the period 1995-2004 (AIHW 2007)[2].

### 1.3 The extent of adult suicide

According to ABS data on *Causes of Death*, published March 2009[3], the suicide rate for South Australia standardised for 2003-2007 is 12.4 suicides per 100,000 compared with the national rate of 9.8. This compares with a rate for 2006 of 10.7 suicides for SA and 8.6 nationally.

Although the Australian suicide data available remains questionable and comparisons between jurisdictions are also likely to be inaccurate (see page 9 for further details), the ABS figures show that suicide rates in South Australia may be higher than the national average. Based on National Coronial Information System (NCIS) data, between 2001 and 2006 there have been an average of 157 suicides per annum for metropolitan Adelaide and an average of 38 suicides per annum from regional and rural South Australia. This gives an average of 195 suicides in South Australia each year. The total averaged notified suicides of registered mental health clients (2006-2009) per annum is 23 in the metropolitan region and four in the regional and rural South Australia.

### 1.4 Indigenous population

Care needs to be taken when interpreting ABS Indigenous data as these data are incomplete and data for some jurisdictions are not yet published. Indigenous people are not always accurately identified in administrative collections (such as hospital records and birth and death registrations) due to definition variations, different data collection methods and failure to record Indigenous status. The rate calculations have not been adjusted for differences in the completeness of identification of Indigenous deaths across jurisdictions.

The ABS published the Indigenous suicide rate for the period 2002–2006 for Queensland, WA, SA and the NT[4]. It is important to note that Indigenous population figures are based on ABS *Experimental Projections, Aboriginal and Torres Strait Islander Australians* (low series, 2001 base). After adjusting for age differences between populations, the suicide rates for Indigenous people for the period 2002–2006 in the jurisdictions for which data are available, are considerably higher than the corresponding rates for non-Indigenous people. According to the ABS analysis, NT had the highest suicide rate per 100,000 population (39), followed by SA (34), QLD (21) and WA (18). Data for NSW, Victoria, Tasmania and the ACT were not reported due to varying coverage across states and territories in the identification of Indigenous deaths in death registrations.

The South Australian Police document used for reporting a death to the Coroner does not have a field for identification of Indigenous status. Therefore there are likely to be a large proportion of South Australian Indigenous deaths stored on the NCIS data base that were categorised as "unlikely to be known". NCIS are currently working with the South Australian Police to amend the document for reporting a death to a coroner to include Indigenous status.

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[2] Australian Institute of Health and Welfare (2007) *Young Australians: their health and wellbeing 2007*.Cat. no. PHE 87. Canberra: AIHW.
[3] *Causes of Deaths, Australia;* ABS Cat. no. 3303.0 : 2009 Report
[4] *Causes of Deaths, Australia; ABS* Cat. no. 3303.0; table 12A.3; 2009 Report, figure 12.43, p. 12.85.

SA Inpatient separations for Suicidal Ideation or Intentional Self Harm for Indigenous persons for 2008-09 indicated disproportionately high hospitalisations in this category, compared to non-Indigenous inpatient separations. These data indicate a need for culturally appropriate suicide prevention services following hospital discharge, targeted towards this high risk group.

### 1.5 Indigenous South Australians with a diagnosed mental illness

SA Health's Northern Mental Health Services Aboriginal Wellbeing & Liaison Program has provided follow-up for a significant group of Aboriginal clients with complex psychosocial needs. In a case series of 50 consecutive clients assessed by the program between late 2008 and April 2009, over 50 percent of this cohort were identified as having suicidal ideation and at high risk of suicide. The issues affecting these individuals and their families included childhood separation from family and childhood experiences of trauma.

### 1.6 Rural and remote South Australia

*"The rate of rural suicide in Australia is among the highest in the developed world. Farmers battle the crippling challenges and profound stresses of years of drought, failed crops, floods, mounting debt and decaying towns. While the overall trend for suicide in Australia has been decreasing, in rural Australia suicide rates have been steadily increasing over the last 30 years. The majority of its victims are men between the ages of 18 and 44. Those at greatest risk of committing suicide are men living in a town with a population of less than 4,000; the more isolated the farmer, the more chance he will resort to suicide"*[5]

The impact of suicide in rural and remote South Australia has an amplified effect on the local communities because of the often extensive familial social networks and ties, and the greater dependency of individuals upon each other in their daily lives. The remoteness of some communities makes difficult for individuals and families to access appropriate services locally post-suicide.

### 1.7 Funding for suicide prevention and support programs in South Australia

The South Australian Government has provided funding towards the following programs, which are explained in further detail in Section 3:

- $1 million in 2005-06 and a further $1.4 million over five years to the Beyondblue depression initiative.
- $300,000 to SQUARE (suicide questions answers resources) between 2005-06 and 2008-09. The Commonwealth ceased funding to SQUARE in June 2009, however the South Australian Government has provided $75,000 funding for SQUARE in 2009-10.
- $408,000 from 2008-09 to 2010-11 to the Mental Health First Aid Program delivered by Relationships Australia SA.
- $195,800 over 2008-09 to 2009-10 to Centacare Suicide Prevention Program ASCEND.

[5] Condon, M (2009), viewed 14 October 2009, http://www.abc.net.au/rural/content/2008/s2543219.htm.

## 2. The accuracy of suicide reporting in Australia, factors that may impede accurate identification and recording of possible suicides (and the consequences of any under-reporting on understanding risk factors and providing services to those at risk)

ABS mortality data are the main source of suicide statistics in Australia. Two other sources of data are Coroner's Offices and the National Coroner's 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. The ABS data contains a caveat that care must be taken in using and interpreting suicide data contained within their publications due to limitations in the data quality.

These data issues mean that analyses are neither comparable nor definitive and it is difficult to interpret the success of plans, programs or interventions that aim to reduce the incidence of suicide in the population. However, the rate of suicide in Australia is widely used as a progress measure. It is important that reliable statistical information on suicide is available to identify change over time.

The key issues in South Australia include:

- In recent years, the ABS has cautioned 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. These delays could be due to:
    - Legislative or regulatory barriers, such as burden of proof requirements[6].
    - Sympathy for the feelings of the family, particularly where the case involves a child or young person.
    - Sensitivity to the cultural practices and religious beliefs of the family.
- Other issues with data collection include:
    - The inconsistent classification and coding of 'causes of death' between State coroners' and across jurisdictions.
    - Changes in definition associated with 'causes of death' and 'intent' of the victim to suicide.
    - The number of cases closed between the publications of ABS data and AIHW reports.
    - Jurisdictional variation in coronial burden of proof requirements when determining suicidal intent.
    - Timing issues associated with the finalisation of State/Territory coronial reports and the coding of that data into the ABS database.
- Statistical analysis of these data for the purpose of 'estimates' of deaths due to suicide in Australia in the years prior to 2007, are likely to be an underestimation. Any

[6] Freckelton I & Ranson D 2006. *Death investigation and the coroner's inquest.* Melbourne: Oxford University Press

comparisons of jurisdictions' suicide rates therefore are also technically unreliable and potentially misleading.

- The ABS has indicated that the reported downward trend in suicide deaths in recent years may be in part due to an increase in the number of open coroners' cases when the ABS finalises its annual suicide statistics.
- Recommendations to improve data reliability in the 2009 AIHW *Review of Suicide Statistics* include methods to improve in the timeliness of the data and exploring the value of standard definitions for statistical purposes with coroners' and other stakeholders.

### 2.1 Youth suicide statistics

There are multiple variables across this demographic which need to be identified to clarify the differential impacts on subgroups. Some of the important variables in South Australia relate to access to a drivers licence, regulations relating to access to alcohol, and socio-economic variables relating to extent of education, employment history, marital status, gender, access to social supports, evidence of mental health and/or substance use disorders.

It would be useful in South Australia to categorise data on youth suicide the following groupings: under the age of 16 years, 16 to 18 years, 18 to 21 years and 21 to 25 years of age.

### 2.2 Country South Australia suicide statistics

The accuracy of suicide reporting in country South Australia is difficult to assess. The stigma of suicide and its repercussions on those involved may prevent individuals from reporting the full details of a case. Many people who attempt suicide are not hospitalised and receive care in other health settings, such as General Practice. Surveillance in these settings could be improved to capture relevant data.

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

Suicide is rarely the result of a single cause. A person's decision to take their own life follows the accumulation of and interaction between numbers of associated factors. These complex and multiple causal factors mean that capacity to identify, influence and affect these factors is not the sole responsibility of one agency, government department or discipline. The National Action Plan for Mental Health 2006-2011 indicates that suicide rates may be improved with comprehensive and integrated mental health services that focus on suicide prevention across the continuum of care (primary, secondary and acute).

Significant levels of collaboration, communication and contribution from governments, private and community organisations, individuals and families affected by suicide, as well as members of the wider community, are essential. However, evaluating the essential elements of collaboration and communication between service sectors and individuals, as well as linking this to outcomes such as a reduction in suicide rates, is difficult.

The South Australian Government is committed to providing services to assist people at risk of suicide, including:

- A Statewide Suicide Strategy is currently under development in South Australia and will be released for broad consultation in 2010. This Strategy will be underpinned by principles targeting:
    - Social Justice - the impact of cost, access, language, gender, age and cultural background can all present barriers to people and may lead to an increased sense of isolation, despair and at-risk behaviors.
    - Coordination - essential in promoting effective linkages between multiple providers including GPs, NGOs, housing, drug and alcohol services.
    - Working together - development of informal and formal networks are critical in addressing suicide and deliberate self harm across communities.
    - Partnerships - developing positive partnerships between State and Federal governments and local governments is essential.
    - Adding value - building on existing structures and programs assists in developing the community's capacity to reduce suicide.
- The current five year Mental Health reform program for South Australia aims to implement comprehensive integrated mental health services, underpinned by the *Mental Health Act 2009*, the Mental Health and Wellbeing Policy and the Mental Health Safety and Quality Framework
- A Mental Health Memorandum of Understanding between the Department of Health, SA Ambulance Service, the Royal Flying Doctor Service and South Australia Police

was signed in 2006. This has increased collaboration and assisted in clarifying the roles of relevant services in assisting individuals at risk of suicide.

- In rural and remote South Australia, the Emergency Triage and Liaison Service, Rural and Remote Mental Health Services, is extremely well utilised by primary health care networks and emergency services to:
    - Assist in coordinating service-wide responses.
    - Assess risk and conduct comprehensive assessments.
    - Provide clinical/operational advice and support.
- South Australia Police investigate death in the community by obtaining accurate data related to suspected suicide deaths and intent.
- The South Australian Youth Welfare Advisory Committee (see 6.1 for further information) recommended that police, in consultation with the bereaved family, will manage the dissemination of information about a youth suicide to the media. The group has also developed guidelines for schools to follow in disseminating information about a student suicide to school communities. These guidelines, including models of letters that may be sent to parents, are publicly available online[7].
- A primary health care suicide prevention and intervention model has been developed for South Australia called SQUARE (suicide questions answers resources) in collaboration with the Federal Government and General Practice SA.
- The Mental Health First Aid Program delivered by Relationships Australia SA aims to assist people at risk through timely access to mental health care that enables prevention of suicide and self-harm.
- Centacare Suicide Prevention Program ASCEND, provides services to young people who are exhibiting depressive, suicidal or self harming behaviours as well as training opportunities for professionals who work with and support young people at risk.

**SA Health 2009-10 Targets to address suicide in South Australia**

SA Health's targets include:

1. Reduce the rates of completed suicides.
2. Develop and implement consistent suicide and suicide prevention protocols across health regions in South Australia.
3. Reduce the harmful after effects associated with suicidal behaviours and the traumatic impact of suicide on family and friends.
4. Improve the mental health of South Australians through awareness, early intervention, crisis treatment and continuing care, as well as professional education.

[7] www.decs.sa.gov.au/docs/documents/1/SuicidePostventionGuideli.pdf

## 4. The effectiveness, to date, of public awareness programs and their relative success in providing information, encouraging help-seeking and enhancing public discussion of suicide

Suicide is a highly emotive topic and data can be misleading. There are risks involved when considering public discussion and the dissemination of suicide information. Public discussion around suicide is often laden with 'reactive' rather than 'proactive' statements which may cause concern to the general public.

Caution needs to be applied when discussing suicide associated activities, public awareness programs and media responses. There needs to be clarification of the aim and purpose of raising the issue of suicide in a public environment. Public discussions around suicide would also need to have appropriate safe and supportive mechanisms in place. These mechanisms include clear and transparent help seeking guidelines and supports as well as strategies to prevent 'copycat' suicides in school communities following the death of a student..

When promoting suicide prevention programs, it is important to understand that one type of approach may not be appropriate for all circumstances. The impact that marginalisation can have, including poor access to education, economic resources, and social support and acknowledging the impact of inequality, age, language, culture, race and gender issues.

There are a wide range of community awareness and skill building mental health initiatives that contribute to raising awareness of the importance of mental health. These messages include self care and enhanced coping, resilience and family and community connectedness. Such initiatives include:

- SA Health is currently developing an anti-stigma campaign as part of South Australia's Mental Health Communication Strategy. While this campaign will not target suicide specifically, it will focus on increasing awareness of risk factors as well as reducing stigma and discrimination associated with mental illness.
- SA Health's Statewide Drought Initiative programs have been successful in increasing mental health literacy and helping develop support networks amongst farming communities across South Australia.
- *Mindmatters* promotes a whole school approach to mental health, wellbeing and suicide prevention, focusing not just on individual students with identified needs but also on entire school communities.
- *Mindframe Media and Mental Health* seeks to influence the media industry and the mental health sector in reporting mental illness and suicide issues responsibly, accurately and sensitively.
- The South Australian Government and Beyondblue partnership aims to reduce the burden of depression and anxiety in the community. The diverse range and reach of programs and initiatives undertaken across South Australia reflect the ongoing success of this partnership.

- *Mental Health Week* is a national annual program that improves community awareness and knowledge of mental health and illness. The key focus of the week is to promote involvement of the South Australians in a range of events and activities aiming to reduce the stigma and discrimination associated with having a mental illness.

## 5. The efficacy of suicide prevention training and support for front-line health and community workers providing services to people at risk

Further research and review is required into the development of evidence based suicide prevention interventions that will focus effort on proven program outcomes. While measuring the efficacy of training and support programs is difficult in the absence of a rigorous evaluation framework, the South Australian Government contributes to suicide prevention training and support for front-line health and community workers through:

**5.1 SQUARE** (suicide, questions, answers and resources) has been developed for South Australia in collaboration with the Federal Government and General Practice SA (2004-2009). SQUARE is a primary health care suicide prevention, intervention and training resource for front line workers model, which promotes assessment and management of suicide risk in patients in the primary health care setting through training programs, packaged resources and follow-up sessions.

The South Australian Government has funded SQUARE in 2009-2010 to deliver the following activities:

- Maintaining the SQUARE website and training programs for front line workers in SA.
- Evaluating the SQUARE resources and suicide networks established through SQUARE activities in South Australia (2004-2009)
- Mapping suicide assessment practice and protocols in currently place in South Australian public mental health community and hospital facilities, including Emergency Department facilities
- Identifying the referral pathways to suicide prevention/support services offered to people who are assessed as being at risk of committing suicide by health professionals working in these facilities

The analysis of the results of the evaluation and mapping activities will inform the development of the South Australian Suicide Strategy in 2010.

5.2 **The Mental Health First Aid Training Program**, which aims to increase the effectiveness of communities to assist individuals who are experiencing distress resulting from mental illness. The program is helping to develop supportive environments that promote safety and resilience for all.

5.3 **Centacare Suicide Prevention Program**, **ASCEND**, provides services to young people who are exhibiting depressive, suicidal or self harming behaviours as well as training opportunities for professionals who work with and support young people at risk.

- The one day Youth Suicide Risk Assessment Workshop has been an integral part of the ASCEND training calendar for at least six years. Over the last 18 months, 269 health, welfare and educational professionals have attended the workshops.

- Since January 2009, ASCEND has had involvement with more than 20 schools, from both the public and Catholic education sectors. Over the last four years of program funding, not one of the numerous suicidal clients with whom they have worked has suicided.

- The 69 face to face consultations and assessments with young people deemed to be at risk of suicide have each resulted in the young person engaging with clinical interventions directly relating to their suicidal ideation and degree of risk.

## 6. The role of targeted programs and services that address the particular circumstances of high-risk groups

### 6.1 South Australian programs targeting youth suicide

Following a number of geographically connected youth suicides in 2006, the South Australian Youth Welfare Advisory Committee was formed with representatives from South Australia Police, Child and Adolescent Mental Health Services and the education sector with representatives from State, Catholic and Independent schools. This Committee meets quarterly and has provided recommendations to address the rise in youth suicides (i.e. schools/copycat suicides) that will be incorporated into the Statewide Suicide Strategy.

The group continues to meet on a regular basis to review emerging information around youth suicide and suicidal behaviour, as well as recognition of students at risk of such behaviour and schools' handling of such concerns.

### 6.2 Centacare's ASCEND program

The South Australian Government provides funding to Centacare's ASCEND Suicide Intervention Program, which provides services to young people who are exhibiting depressive, suicidal or self harming behaviours as well as training opportunities for professionals who work with and support young people at risk.

The one day Youth Suicide Risk Assessment Workshop has been an integral part of the ASCEND training calendar for at least six years. Over the last 18 months, 269 health, welfare and educational professionals have attended the workshops. It is designed to:

- Provide participants with an overview of suicide and suicidal behaviour in Australia
- Increase understanding of protective and risk factors
- Detect and explore suicide risk
- Formulate management plans
- Understand the importance of self care.

Within Centacare, Suicide Risk Assessment Training completion is mandatory for all staff who have contact with clients.

Since January 2009, ASCEND has had involvement with more than 20 schools from both the public and Catholic education sectors. Over the last four years of program funding, not one of the numerous suicidal clients with whom they have worked has suicided.

### 6.3 Targeted programs for people with a mental illness at risk

Consistent national standards on suicide risk assessment could be developed for targeted groups. A range of policy and practice issues that are similar across target groups include:

- The need for ongoing mandatory staff training in the management of risk.
- Individual care plans specifying action to be taken if consumers are non-compliant or fail to attend appointments.
- Development of key management principles for the follow up of consumers at risk of suicide post Emergency Department presentation/inpatient unit discharge.
- For people with a dual diagnosis of mental illness and substance misuse, there is a need for staff training in substance misuse management, working with drug and alcohol services, which includes local clinical leadership to support staff in implementing best practice.
- Consideration of short term assertive, alternative treatment options for males after a first presentation to a mental health service in the context of a crisis, usually via a public hospital Emergency Department following suicide attempt.
- Ensuring that Mental Health Care Plans for registered mental health clients assessed as at high risk of suicide receive peer review.

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

### 7.1 International research into suicide and suicide prevention

The World Health Organization declared suicide as a priority for the first time in the year 2000 (World Health Organization, 2001)[8] and calculated the number of recorded suicide deaths to be 815 000 worldwide (0.0135 percent of the global population), a burden slightly lower than the estimate of one million published in an earlier technical report dedicated to suicide (World Health Organization, 1999)[9].

Systematic reviews of research conducted on the effectiveness of suicide-preventive interventions and national suicide prevention plans in developed nations have identified that they are rarely evaluated[10]. The analyses from the reviews identify that depression recognition and treatment by physicians and restricting access to lethal methods reduce suicide rates. However, it is clear that other interventions need more evidence of efficacy. In particular it is essential to ascertain which components of suicide prevention programs are effective in reducing suicide rates.

The most common reasons cited in the literature for this lack of evidence associated with the effectiveness of preventive efforts are[11]:

- Inadequate sample sizes for randomised, controlled studies (Gunnell & Frankel, 1994)[12] and programs of insufficient duration (Goldney, 2000)[13].
- Numerous biases inherent in suicide research include difficulties in creating clusters of participants with similar problems, the use of retrospective evaluations, the lack or inadequacy of control groups, and the design of psychological investigations performed on proxies of the deceased (psychological autopsies) (Hawton et al, 1998)[14].

There is little known about the efficacy of factors that are likely to protect against suicide, such as coping skills, problem-solving capabilities, social support and connectedness because they are poorly investigated. More research is needed in this area.

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[8] World Health Organization (2001) World Health Report. Geneva: WHO

[9] World Health Organization (1999) Figures and Facts About Suicide. Technical Report. Geneva: WHO

[10] John Mann; Alan Apter; Jose Bertolote; et al. (2005) Suicide Prevention Strategies: A Systematic Review JAMA. 2005;294(16):2064-2074 (doi:10.1001/jama.294.16.2064)

[11] Diego De Leo: (2002) Why are we not getting any closer to preventing suicide? British Journal of Psychiatry (2002) 181.372

[12] Gunnell, D. and Frankel, S. (1994) Prevention of suicide: aspirations and evidence. British Medical Journal 308: 1227- 1233.

[13] Goldney, R. D. (2000) Prediction of suicide and attempted suicide. In The International Handbook of Suicide and Attempted Suicide (eds K. Hawton & K. Van Heeringen), pp. 585-595. Chichester: John Wiley & Sons.

[14] Hawton, K., Arensman, E., Townsend, E., Bremner, S., Feldman, E., Goldney, R., Gunnell, D., Hazell, P., van Heeringen, K., House, A., Owens, W., Sakinofsky, I., and Traskman-Bendz,L. (1998) Deliberate self harm: systematic review of efficacy of psychosocial and pharmacological treatments in preventing repetition. *British Medical Journal* 317: 441-447.

## 7.2 Research into international trends in suicide rates linked to suicide prevention plans

Western countries are facing a general decline in suicide rates that appears to be unrelated to the existence of any national plan. For example, reductions in suicide rates have occurred in Finland, Sweden, Norway and Denmark (which had or have a structured strategy), and also in Hungary and The Netherlands which have not developed a national prevention program.

The international evidence suggests countries should not rely on epidemiological surveys and prevention strategies developed elsewhere. Cultural factors have a major role in suicidal behaviour (Vijayakumar & Rajkumar, 1999)[15] and there are vast differences in the dimension and characteristics of this problem around the world.

Despite the strong association of suicidal behaviour with mental disorders, there is little research associated with the impact of treatment services in reducing the advent of suicide in known at risk groups. Follow-up of consumers considered at risk of suicide, who are admitted to hospital or referred to treatments such as depression groups counselling services or cognitive based therapies in the community, is critical. Policy makers and researchers need to disseminate adequate information to ensure staff are aware that a portion of chronically suicidal individuals are likely to commit suicide, despite the best available treatment and effort.

Greater use of antidepressant drugs to prevent mood disorders, functional neuro-imaging, and genetic and psychometric screening for early detection of impulsive behavior and suicide proneness seem to hold promise for future prevention strategies (De Leo 2002).

Suicide research requires major investment, using multi-disciplinary teams across agencies and more integrated approaches for large scale, long-term and thoroughly evaluated projects.

[15] Vijayakumar, L. & Rajkumar, S. (1999) Are risk-factors for suicide universal? A case—control study in India. *Acta Psychiatrica Scandinavica*, 99, 407-411

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

The Spencer Gulf Rural Health School (SGRHS) was contracted to conduct an evaluation of four multi-focused community-based initiatives in different localities across South Australia that were allocated funding under National Suicide Prevention Strategy. The South Australian Government would like to refer the Senate Committee to the final evaluation report available at:

- http://sgrhs.unisa.edu.au/resources/DocCentre/Dnld_Pubs/R%26E/SANSPS_Volume1.pdf
- http://sgrhs.unisa.edu.au/resources/DocCentre/Dnld_Pubs/R%26E/SANSPS_VOlume2.pdf
- http://sgrhs.unisa.edu.au/resources/DocCentre/Dnld_Pubs/R%26E/SANSPS_VOlume3.pdf

Further research will be required to determine which components of the National Suicide Prevention Strategy have been effective.

SA Health's Country Mental Health Services has provided the following comments on specific parts (in italics) of the LIFE (Living is for Everyone) Fact Sheet 18 *Suicide in rural and remote communities.*

1. *"focus on health and wellbeing, rather than illness or mental health problems. Many people from rural and remote communities prefer to focus on finding solutions, rather than dwelling on problems and difficulties*"

   Mental health services need to promote resilience and focus upon health and wellbeing, which may reduce the incidence of mental illness, but not at the cost of failing to address the pain of untreated illness which contributes to higher rates of suicide.

2. *"use community networks to build resilience and coping strategies among people in rural and remote communities, so that communities can work together, support each other, and have the skills to respond effectively to people in need. For example, social and sporting groups provide an opportunity to build awareness of suicide, mental health and related issues, encourage social connectedness, and build community capacity"*

   It is important to note the paradoxical nature of many rural and remote communities. While residents often do support each other, communities are also fractured due to the daily struggle to survive and competition amongst farmers and local businesses.

3. *"promote acceptance for talking about emotional issues and difficulties"*

   The importance of providing well-funded programs that utilise statewide and local media to promote acceptance has been well demonstrated through the Drought Initiative Programs and the impact of using local media cannot be overemphasised.

4. *"involve people in the community in designing and implementing programs. People in rural and remote communities should be involved in identifying the best ways to*

*provide support and care in their community, and how they can contribute their skills to suicide prevention initiatives in the community"*

SA Health's Country Mental Health Services support programs that focus on the unique challenges in rural communities, that consult the local community when developing solutions, and tailor strategies for rural areas as opposed to the "one size fits all approach".

5. *"create networks within rural and remote communities where people can meet, discuss issues and socialise, whether in person or via phone or the internet. Identify local community leaders who can maintain regular contact with community members and build awareness and support for suicide prevention activities and initiatives"*

   This strategy supports local mental health Models of Care, through the development of local service networks based around communities of interest.

6. *"promote awareness among service providers of the various ways in which people in rural and remote areas may respond to difficult or traumatic circumstances, and of their varying needs"*

   It is critical that there is a good connection between service providers and the local communities.

7. *"provide training for health professionals working in rural and remote areas (e.g. local doctors, visiting health services personnel) to recognise and respond to the warning signs of suicide, suicidal behaviors and mental illnesses that are strongly associated with suicide (e.g. depression)"*

   Continuity of health professionals is a critical factor in developing the trust and support needed to recognise and respond to the warning signs of suicide. Continuity is especially challenging in rural and remote South Australia.

**Progress in mental health reform in South Australia**

South Australia is progressing substantial mental health reform. The State Government endorsed *The Stepping Up: A Social Inclusion Action Plan for Mental Health Reform 2007-2012* report released by the Social Inclusion Board in February 2007. The government supported all of the report's 41 recommendations and has allocated $107.9 million to implement the recommendations.

The aim is to ensure that all people with a mental illness have access to high quality, client focussed care through the implementation of a stepped system of care and the creation of an integrated system of primary, community and acute mental health care services, with clearly defined care pathways and effective referral services.

Key priorities in the report included:

- Implementing a stepped system of care with community mental health teams at the centre
- Tackling the crisis in acute psychosis care by having a targeted response to people with chronic and complex needs
- The redevelopment of Glenside Hospital as a centre for specialist mental health services.

*The Mental Health Act 2009* has also been introduced to support the reforms.

Stepped system of care

- The stepped system of care will play an important role in providing a system of mental health care in South Australia that ensures people with a mental illness can access the level of care that meets their needs and best promotes their recovery.
- Key elements of the stepped system of care include secure care, acute care, intermediate care, community recovery centres, supported accommodation and community mental health centres.
- Overall, the reforms will see 86 additional adult mental health beds created across South Australia, including new intermediate care beds and supported accommodation places.

To date, key milestones in implementing the stepped system of care include:

- The allocation of $18.2 million to create 90 new intermediate care beds, 60 at four centres across Adelaide and 30 in the country. Construction of two 15 bed intermediate care centres at Glenside and Noarlunga has already commenced and negotiations will soon be completed for a site at Queenstown in western Adelaide. A search for a site in the northern metropolitan area is continuing. It is expected that about 20 intermediate care places will be available in country South Australia by late 2010.
- The opening of three 20 bed community recovery centres at Mile End, Noarlunga and Elizabeth during 2007 and 2008.
- The allocation of $20.46 million to create 73 extra supported accommodation places across Adelaide. Two experienced community housing providers (Unity Housing Company and Southern Junction Community Services) have been appointed to construct and manage the community based accommodation.

Twenty supported accommodation units will be constructed on the Glenside Campus as part of this allocation. Service development work is well underway to establish the support services and partnership arrangements for the program.

The Glenside Campus Redevelopment

- Glenside will continue to have a significant role under the new reforms as a centre for specialist mental health services. The Government has allocated $130 million for the redevelopment of the site.
- The Master Plan for a modern 129 bed hospital in the Glenside Campus was released in April 2008. The redevelopment will also include a 15 bed intermediate care facility and 20 supported accommodation places.
- The concept plan for the redevelopment of the Glenside hospital has recently been released for public consultation.
- The redevelopment will maximise the facilities available, while ensuring the best possible use of open space and the integration of mental health services into the wider community.

Community mental health

- A review of community mental health services was completed in 2008, providing further directions for community mental health reform.
- The Adult Community Mental Health Services Integrated Model of Care has recently been released after collaborative consultation with people with a mental illness, carers, government and non-government agencies.
- Significant work is now being undertaken to develop all of the operational practices and procedures that will underpin the new model of care, as are arrangements to meet the training and development needs of the mental health workforce.
- A comprehensive business case has also been completed to provide direction for the establishment of six community mental health centres in six service catchment areas across the metropolitan area. Funding of $25.92 million has been allocated to develop the centres. The centres will be critical to improving service delivery and providing integrated services.

Models of care

- New models of care have been developed for acute inpatient care, intermediate care, secure care, supported accommodation, aged care, psychiatric intensive acute care and perinatal and infant care.

Work with the non government sector

- The Government allocated $36.8 million over four years to provide community non clinical based services to people with a mental illness.
- The Government of South Australia has also reviewed its commitment to strengthening its investment in non government services.
- Commencing in April this year, funding of $8.4 million per annum has been distributed to the NGO sector for the delivery of the new Individual Psychosocial Rehabilitation Support Services program. These services will provide significant support to around 500 people in their homes and communities.

- Funding support for the NGO sector has increased from $3.43 million in 2002-03 to $24 million in 2008-09.

Youth first episode psychosis

- The Government of South Australia has allocated $1.6 million to provide early intervention for young people experiencing mental illness for the first time, including the establishment of an outreach service.
- A review of service was conducted, and a new model for the provision of services for first episode psychosis has been endorsed.
- Governance arrangements and a site for the delivery of the youth first episode psychosis services have been completed and the service will commence once the recruitment of all staff has been finalised.

Recruitment of nurse practitioners

- The Government has also made $1.6 million available to recruit eight nurse practitioners across country South Australia.
- The aim is to improve access to services for people who are at risk due to a shortage of general practitioners and a limited number of visiting psychiatrists.
- The recruitment of the first four nurse practitioners in the country has now been completed.

New mental health legislation

- In June 2009, the *Mental Health Act 2009* was passed by the South Australian Parliament.
- The new legislation will come into effect on 1 July 2010 and will support mental health care reform in South Australia.
- Some of the key changes of the legislation will be to:
    - Change the criteria for the making of Community Treatment Orders and Detention and Treatment Orders to ensure greater protection of individual rights and facilitate access to assessment and appropriate treatment early in an episode of serious mental illness
    - Establish the Office of the Chief Psychiatrist, who will play a key role in promoting safety and quality in mental health care and improving reporting, monitoring and accountability in the mental health system
    - Make treatment and care plans mandatory for all patients, except those on Level 1 Orders
    - Improve provisions in relation to patient transport, allowing mental health clinicians, ambulance officers, Royal Flying Doctor Service medical officers and flight nurses to transport people with a mental illness
    - Increase the recognition of the role of families and carers, including their role in treatment and care planning
    - Enhance provisions governing the appropriate disclosure of relevant information
    - Establish a Community Visitor Scheme in South Australia.
- A project team has been appointed to manage the implementation of the Act and ensure that carers, people with a mental illness, staff and the general community have access to information and relevant training about how the new legislation will work.