Senate Inquiry into Suicide in Australia

I thank the Committee for the opportunity to make this personal submission.

The Committee's interest in suicide prevention is welcomed by all in Australia concerned about mental health, health and social well-being.

This submission is drawn from my experience in medicine, community medicine and public health and from my involvement with non-government and government organisations and as Chair of the Australian Suicide Prevention Advisory Council (ASPAC) and previous national advisory councils on suicide prevention.

Opening Statement:

The national concern about suicide and suicide prevention started in the late nineties. The rates of youth suicide were increasing at that time.

Australia was one of the first countries to take up the national suicide prevention as recommended by the UN in 1996.[1] This was well before the U.S., UK and other countries. Canada, for example, still does not have a national suicide prevention strategy.

The Australian initiatives started in 1995 with **"*Here For Life: A national plan for youth in distress*"**. Later in that year the **National Youth Suicide Prevention Strategy** was established. The West Australian Government had appointed a Youth Suicide Advisory Committee in 1989.

Because of the complexity of suicide prevention and a paucity of evidence and guidance about what should and could be done the Commonwealth Government appointed an advisory committee to oversee the national approach – the council was representative of community organisations, the mental health sector, consumers and business.

Additionally a set of advisory mechanisms were established for input from community representatives and experts and from state based advisory committees.

National Action Plan for Suicide Prevention

In 1998 the **National Action Plan for Suicide Prevention** commenced. The plan was developed by the **National Advisory Council on Suicide Prevention**.

The strategic framework for suicide prevention known as the LIFE Framework (Living Is For Everyone) was disseminated in 2001.

The **LIFE Framework** is a blueprint for suicide prevention across Australia both for government and civil society organisations. It is not a strategy nor is it prescriptive. It is a set of guidelines about what could be done and what is known to be effective for suicide prevention.

The Framework has attempted to engage the range of sectors which can contribute - directly and indirectly - to suicide prevention, whether government or non government.

It is used extensively across Australia.

The approach

Governments have conceived suicide prevention as a public health and community development "project" in the broadest sense.

The funding programmes of the Australian Government have fallen into two groups - national (mainly universal) and community based (capacity building and developmental). Many of the projects/programmes initiated through the National Suicide Prevention Strategy have made presentations to the Committee throughout the Inquiry.

Of more recent times mental health funding and other initiatives through the Council of Australian Governments have addressed suicide risk and prevention well beyond the funding available through the National Suicide Prevention Strategy.

Project review and evaluations

Every funded project has had the expectation and requirement that it be evaluated against agreed objectives, i.e. objectives defined by the organisations in their proposals. Each organisation has received guidance on how to undertake evaluation. These evaluations and higher level reviews and evaluations have influenced the direction of the National Suicide Prevention Strategy.

A decade ago the emphasis was mainly on universal programmes, building resilience and capacity and on community based projects. In the current period there is a stronger focus on high risk groups and settings.

What works?

Some of the major influences which have contributed to the reduction of suicide rates in Australia have included domains outside the conventional constructs of mental health and mental illness.

These factors have been –

- Improved public awareness of mental health and the risk factors for depression and suicide.
- More balanced and enlightened public media discussion of issues related to mental health (in the broadest sense) and suicide.
- Consumer involvement and advocacy in mental health and related issues.
- Increased awareness of suicide in community-based organisations.
- Reduction in access to barbiturates.
- Gun control initiatives.
- Reduced carbon monoxide emissions from motor vehicles.
- Declining illicit and related drug use.
- Reductions in overall alcohol consumption.
- Involvement of primary health care providers in mental health and suicide awareness.
- Possibly increased access to effective treatment of depression

Overall evaluations

It is not an easy task to evaluate complex social/health programmes and this is certainly the case with suicide prevention in which, from an epidemiological perspective, the outcome of suicide is a relatively rare event and makes studies of the effectiveness of interventions in populations difficult to undertake.

Since the late 1990s, at different points in the evolution of suicide prevention, there have been evaluations of components of the suicide prevention strategy and of its overall achievements.

The early evaluations appeared in a series of books entitled *"Valuing Young Lives"* published by the Australian Institute of Family Studies; author Dr. Penny Mitchell. The subsequent overall evaluation in 2005 has been summarised in the submission from the Commonwealth Department of Health And Ageing to the Inquiry.

The conceptual framework for these evaluations has been based on a concept known as Programme Logic; indeed, this was the approach required by the Department of Finance and Treasury.

One of the best examples of the programme logic approach was developed for the national strategy and implemented in Victoria by the *Centre for Development and Innovation in Health* at the *Australian Institute of Primary Health Care* at Latrobe University, Victoria.

As already stated the Committee has received information about the 2005 evaluation which, with community consultations, informed the change in focus of the current suicide prevention strategy.

The Commonwealth Government is proceeding to establish an evaluation for the more recent period.

It should be said, that suicide is the worst outcome for mental illness; it is also the worst outcome of chronic physical illnesses such as unremitting pain, progressive disablement, diminishing mental capacity, from alcohol and drug problems and from social sequestration.

Suicide can be, and often is, the outcome of intolerable suffering.

Committee's Terms of Reference:

This submission addresses the Committee's Terms of Reference (ToR) as set out below.

In reviewing the ToR there are some additional areas which merit consideration: -

1. The creation and maintenance of social support and relationships in communities, for example, the Government's agendas for Social Inclusion and Closing the Gap for Indigenous people.

2. The ways of limiting access to the means of suicide.

3. The involvement of all branches of the health and social systems. For example, in health care, suicide can be an outcome of insufferable physical illness and disablement. It is not a problem confined to mental illnesses or disorders.

Submission from the Department of Health and Ageing

The Department's submission is based on advice that the Australian Suicide Prevention Advisory Council has given to the Minister and Department.

LIFE Framework

The LIFE framework is a blueprint not a prescription for suicide prevention. It was commenced in 1998 by the National Advisory Council for Youth Suicide Prevention and approved in 2000 for all age groups by the National Advisory Council for Suicide Prevention and the then Minister for Health.

The Framework aims to foster evidence-based government policies and programs, organisational and community development and first-rate frontline practice.

The State and Territory governments and non-government organisations model their suicide prevention plans and actions on the LIFE Framework.

The goals are to: -

1. 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;

2. Enhance resilience and resourcefulness, respect, interconnectedness and mental health in young people. Families and communities, and reduce the prevalence of risk factors for suicide;

3. Increase support available to individuals, families and communities affected by suicide and suicidal behaviours;

4. Provide a whole of community approach to suicide prevention and to extend and enhance public understanding of suicide and its causes.

It has six action areas:-

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

The Framework incorporates universal, selective and indicated interventions.

The National Suicide Prevention Strategy

The objectives of the National Suicide Prevention Strategy are informed by the LIFE Framework.

1. ***Enhance protection against suicide*** – to protect against suicidal behaviour, through preventative measures and by promoting wellbeing, optimism and social connectedness;
2. ***Improve early identification and intervention*** – to better identify and help people at risk of suicide by improving community attitudes, understanding and awareness;
3. ***Improve crisis support and ca***re – to improve support and care for people who have attempted suicide;
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
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.

An Action Framework for Suicide Prevention

The Department of Health and Ageing submission details the Action Framework and is based on the following principles agreed by ASPAC:-

- Alignment
- Leverage
- Embeddedness
- Universal suicide prevention activity
- Selected and indicated suicide prevention activity
- National and local
- Evidence, data and evaluation

Australian Suicide Prevention Advisory Council (ASPAC)[2]

ASPAC advises the Minister of Health and Ageing and works with the Department.

Members:-

- Ms Dawn O'Neil – CEO, Lifeline and member of the National Advisory Council on Mental Health;
- Dr Michael Dudley – Chair of Suicide Prevention Australia and Senior Staff Specialist in Psychiatry, Prince of Wales and Sydney Children's Hospitals;

- Ms Wendy Sturgess – CEO, Crisis Support Services;
- Professor Diego de Leo – Director, Australian Institute for Suicide Research and Prevention;
- Professor Brian Kelly – Director, NSW Centre for Rural and Remote Mental Health;
- Ms Barbara Hocking – Executive Director, SANE Australia;
- Ms Janet Meagher – Consumers' Health Forum of Australia; and
- Ms Adele Cox – Chair, National Indigenous Youth Movement.
- Associate Professor David Ransom – Deputy Director Victorian Institute of Forensic Medicine
- Professor Ian Webster, Emeritus Professor of Public Health & Community Medicine, University of NSW.

Senate reference:

The impact of suicide on the Australian community including high risk groups such as Indigenous youth and rural communities, with particular reference to: the personal, social and financial costs of suicide in Australia;

Loss of productive life: There are greater numbers of young people notably young adults of working age who take their lives by suicide. This means a high loss of productive lives to society.

Impact on others: The personal costs of suicide include the impact of bereavement on individuals close to the person but the effects extend in waves to affect many others: doctors and nurses feel the loss; they can feel as if they have failed the person. Police officers, teachers, ambulance officers, railway workers, lawyers, work friends, employers – the ramifications can be very wide – can all be affected and need support following a suicide. The loss and grief can affect work places, clubs, schools indeed whole communities such as regional areas and townships.

Economic costs: Some estimates have been made of the costs of suicide but I am unaware of rigorous economic studies of the health and social costs of suicide.

Cost effective studies: It would be useful to undertake some cost effectiveness studies as has been done in other areas to see which interventions are the most cost-effective. I suspect that some of those currently in vogue may not stand up well to this test. See for example the work done by Associate Professor Chris Doran (National Drug and Alcohol Research Centre, University of New South Wales) and others on the cost-effectiveness of interventions in alcohol.

Senate reference:

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);

Suicide is a complex social phenomenon influenced by a range of adverse factors; it is also an intensely personal event in which it is impossible to truly know the mind and intention of the person at the time of death.

The determination of suicide is not a purely scientific question as it requires social judgments and the capacity to engage with and appreciate the mental processes of another person.

As a result there will be variation in the interpretation of data and, indeed, different views of a person's mental state, intentions and the will to live.

As Professor Robert Goldney has said in his submission to the Inquiry:

> *"Suicide is undoubtedly under-reported, and that has probably always been the case. The reasons for this include State or Religious sanctions; there may be insurance considerations; there is family and community sensitivity about the recording of suicide; different professions are entrusted with the delineation of suicide; and there are differences between clinical and legal definitions of suicide."*

Chronic suicide: In homeless people and people with complex comorbidities of mental health, alcohol and substance use problems and physical disabilities a person's quality of life can be much diminished. Life for many of these people has lost its meaning and there are higher levels of exposure to risk and self harming behaviour. It is as if they no longer care and have "lost the will to survive". This is a kind of "chronic suicide" but that idea is not part of the contemporary view of suicide.

Level of under-reporting: The level of under-reporting in recent times has been variously estimated to be in a range of 15% to 25%. We do not know what it was like in the past.

The ABS report on suicides released on the 31st March 2010 estimated that in 2007 the under-reporting was of the order of 9%. The ABS has revised its methodology of coding for 2008 so that a proportion of the cases not yet determined by coroners were coded as suicides; the annual estimate for 2008 being 2191 suicides. I understand the interpretation is that this number does not represent a real increase in actual suicides.

The ABS has cautioned, "the increase in the number of deaths classified as Suicide between 2007 and 2008 may be overstated and users are advised to read the technical notes and use caution.[3]

Colleagues in public health and epidemiology have advised me that Australia's documentation of deaths and suicides is regarded as of the highest standard internationally. The ABS has undertaken to maintain a constant review and update of its procedures as appropriate and other measures related to the recording by police and the determination of suicide by coroners remain to be developed and implemented.

Decline in suicides: Suicides have declined since the peaks in years around 1997, even allowing for the fact that there may have been under-reporting in recent years.

This is consistent with declines in deaths from related causes and in other causally-related phenomena: firearm deaths, homicides, illicit drug deaths, alcohol caused deaths and the levels of alcohol and drug use.

Suicide and related data[4]

	1997	**2007**	% change	Source
All suicides	2720	1881	-33.7 %	ABS
15-24 suicides	510	244	-52.0%	ABS
Drug related suicides (poisons)	309	185	-40%	ABS
Other poisons - (CO) – suicides	671	249	-63%	ABS
Firearm suicides	329	155	-53%	ABS
All firearm deaths	431	307 (2004-5)	-30%	AIHW Injury Research Series No 57

Homicide victims	366	286	-22%	AIC
Alcohol - deaths	3255	3143(2004-5)	-3.4%	National Alcohol Indicators
Opiate deaths	713	374	-47%	NDARC publications
Any illicit drug use	22.0%	13.4%	-39.1%	National Drug Strategy, AIHW

Mental health and suicidal thinking: The National Surveys of Mental Health and Well-Being in 1997 and 2007 while showing little change in the prevalence of mental disorders in the population between 1997 and 2007 have shown a small decline in suicide thinking during that 10 year period.[5]

Senate reference:

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;

It is the frontline health and other human services such as family support, legal services, the courts, homelessness shelters, coroners' offices and the like, that are exposed to the highest prevalence of people at risk of suicide.

All frontline services need to be aware of suicide risk, how to assess risk and how to provide immediate support and referral to ongoing care.

This is the essence of the idea of embedding suicide prevention in all health and human services as in ASPAC's Action Plan.

Emergency departments: Emergency departments are critical in responding to those who present having attempted suicide and other high risk situations such as intoxication and mental disturbances. The key issues are that the suicide risk has to be identified and that a "chain of care" is established from the initial point of engagement with the emergency department.

There are other health services in which the patient population is at high risk of suicide – pain clinics, drug and alcohol services, aged care, and rehabilitation and in the follow-up of trauma and chronic medical conditions. Thus reinforcing the need to embed suicide assessment and prevention in all health services

Prisoners: In the period after release from prison ex-prisoners are at very high risk of suicide. Again the need for a "chain of care".[6]

Law enforcement: Police officers are very often the first to respond to someone at risk of suicide. They have a unique role in situations where a person is threatening to take their own lives such as in jumping from a high place or in siege situations. The police tactical response groups are very commonly called to situations such as this. The front-line officers need to be supported in these roles by other services.

The ability to respond to the imminent risk of suicide is a key task for all front-line health and human services.

Alignment of policies: For governments this means that national and state government mental health, health and other relevant social programmes should be aligned with a national suicide prevention strategy so these other programs can act out their important roles in suicide prevention.

Senate reference:

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

Media and 'normalisation' of mental health

Mindframe: Mindframe is a highly regarded national programme to de-stigmatise mental illness and to influence public discussions about suicide and self harm so that the discussions are careful and deal with broader causal issues such as the risks, vulnerability and protection rather than the sensational aspects of suicide incidents. Sensationalism has the potential to cause harm and to promote emulation.

"Response Ability": A related project - "Response Ability" - introduces into university departments of journalism, material and course resources about interviewing, writing and broadcasting mental health and suicide related issues. "Response Ability"has extended its training into police services, the court system and into stage and screen writers.

Involvement of the media and press

A central element of the Mindframe initiative is the involvement of journalists, editors and members of the Press Council in shaping the guidelines for reporting of suicide.

The "normalisation" of mental health problems has been an important feature of public "health" in Australia led by well-known figures – politicians, sportsmen and sportswomen and actors – describing their own struggles with depression.

Community organisations and community attitudes

Non-government organisations: Non-government organisations - "beyond blue" depression initiative, "The Black Dog Institute" and other agencies and the Government's anti perinatal depression initiative have all been instrumental in increasing public understanding of mental illness, the risk of depression and suicide.

Help-lines and websites: There are an increasing number of first contact and access points for distressed people such as Lifeline, Kids Helpline, Crisis Support Services, Mensline, Salvo Care Line and other helplines and web-sites - such as those for people with the drug and alcohol problems – ADIS (Alcohol and Drugs Information Service, NSW) and Direct line at Turning Point in Victoria - and others concerned with domestic violence and other issues. These sources of help provide support to distressed and confused people not in contact with formal health services.

Monitoring stigma

*"S**tigma Watch"***: SANE is funded by the Commonwealth Government to run "Stigma Watch" which monitors the reporting of suicide in the public media and responds to harmful portrayals by contacting journalists and media organisations to suggest how the information might have been presented in less harmful ways.

Media research: Research undertaken by Dr. J Pirkis at the University of Melbourne and others has shown that the reporting of suicide and mental health has improved over time. There is more coverage and it is less sensational, less pejorative and stigmatising and is generally more careful and thoughtful than in the past.

While these achievements have not attracted much interest in Australia the achievements have been recognised in international publications such as the British Medical Journal.

Raising community awareness[7]

Suicide awareness raising: There are many projects and endeavours around the country to raise awareness of suicide prevention. These activities have mainly involved community groups, certain professions, local organisations and services.

However, awareness of suicide risk has not permeated health services to the extent that is needed. For example, addiction specialists are generally unaware of the suicide risk in their patients, yet alcohol and other drug problems carry high risks for suicide.

Potential for harm in "awareness" programmes

Some well-intentioned projects to "raise awareness" have the capacity to engender anxiety, stress and thoughts of suicide and self harm. The motivation to become involved in raising awareness in the public may come from a parent or another person who has lost someone by suicide important to them and they want to do something about it. Harm can be done – by heightening anxieties and distress, creating unreasonable expectations and in uncommon but significant circumstances *legitimise suicide* as a way of resolving overwhelming life problems.

Awareness raising can be done well and is an important strategy when carefully conceived, run thoughtfully with organised follow-up and feedback.

Specific awareness programmes

ASSIST: The ASSIST programme managed through Lifeline's *Living Works* programme is an example of an effective awareness raising programme. ASSIST has been used in local community settings and with a range of human service organisations. These workshops help people apply suicide first aid in a range of settings - with family, friends, co-workers and team mates and in more formal helping roles. It has been taken up in the professional development of workers in suicide intervention training.

The Australian Government funded ASSIST workshops in the Northern Territory. This programme also aimed to make ASSIST acceptable and appropriate to Indigenous people. Evaluation showed these learning events were very well attended; at higher rates than in some other communities and settings. Evaluation of the Northern Territory ASSIST workshops showed they were appropriate and relevant.

Mental health first aid

Mental health first aid: This is a practical and welcome approach to enhancing the understanding in the community of mental distress and suicide. It imparts skills to ordinary people on how to respond to mental health distress and crises in others. The project team from Melbourne University has been funded to adapt mental health first aid to make it relevant to Indigenous communities. The aim is give some skills to community members to enable them to help someone developing a mental health problem or who is mentally distressed. The course is based on the

idea that a mental health crisis, such as the risk of suicide, can be prevented through early intervention in people developing mental disorders. In crisis situations the course assists by providing advice about how to respond to a person in these circumstances.[8]

Many Mental Health First Aid programmes have been run in communities at risk, for example, rural communities.

Broader impact of suicide awareness

Mental health literacy: It is my opinion that awareness programmes about suicide, mental health and depression have assisted with a broader understanding of mental illness and suicide prevention in the Australian community.

This awareness has made a significant contribution to mental health promotion and prevention and to the population measures for suicide prevention.

Senate reference:

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

This has been a significant area of funding from Government to community groups and communities. The submission from the Commonwealth Department of Health and Ageing has documented the current programmes.

Awareness and front-line workers

Being alert to suicide risk and how to engage with indications of distress is very important for workers and frontline agencies – welfare organisations, courts, legal staff, police, correction services, Centrelink, community organisations and so on.

In the health care system where the prevalence of people at risk is high, tailored approaches to awareness, risk perception, assessment, interventions and continuing care are needed.

This is especially important - in general practice and primary health care, mental health services, drug and alcohol services, pain services and Emergency Departments.

Policy and front-line practitioners

Government and public institutions can set parameters for performance and disseminate research evidence to inform their own staff, professionals, other service providers, patients and clients.

In health services this means investing in professional education, skill development and in interviewing, assessment and counselling methods for circumstances in which the problems relate to a person's beliefs, emotions and mental health. A most important task is to change the paradigms of disease and treatment to include psychological and mental health issues in all health care settings.

Changing the culture of health and human services

A change in culture of this kind is a major undertaking as much medicine and health care centres on organic disease and injuries to the exclusion of psychological and social factors and nuances.

The sensibilities of a significant number of people who work in health care is antithetical to engagement with distressed persons and their mental state, and the environments of care are often not conducive to such engagement.

Where such inadequacies are recognised they need to be overcome by arranging for referral of the person at risk to other service providers who have the interest and skills to deal with mental health issues; or the service providers need to be retrained to undertake this type of work.

It is unfortunately the case that in the health system, and other service systems, professional status and prestige gets in the way of spending time "listening" to the patient and in practising a ''patient orientated'' approach to clinical care.

The preparedness to engage with mentally distressed people and those at risk of suicide should be part of the repertoire of all human service professionals and front-line staff.

The responsibility to promote these changes lies within the leadership of the professions, health services and educationalists. For example, suicide risk assessment and prevention should be included in the teaching programmes of all health professionals.

Examples of interventions to change skills and culture

General practice

The Government has funded mental health skill development in primary health care through the divisions of general practice. Such skill development has included programmes for the management of depression and co-existing mental health and substance use disorders, for example, Managing the Mix (jointly funded by the Alcohol Education and Rehabilitation Foundation and Commonwealth Departments of Health and Ageing and Veterans Affairs.

Additionally Medicare Health Insurance Benefits have been re-structured to provide incentives for general practitioners to take on mental health cases and to develop mental health plans for their patients.

Medicare funding has also been extended to psychological consultations for persons referred from general practitioners recognised for their interest and skills in mental health. As a result there is much greater access in the community to psychological services than before when such services were unavailable to low income patients.
Suicide awareness training has been introduced in community settings, for example, in rural and remote areas, and into relevant community based organisations. Similar programmes have been introduced into the Family Court and Centrelink. Reference has been made to suicide awareness training in the sections, Community organisations and community attitudes and Awareness and front-line workers above.

Emergency departments

There are examples of Emergency Departments which have been strengthened by the presence of mental health and, to a lesser extent, drug and alcohol staff to better manage patients who present with mental health and drug and alcohol problems and suicide risk.

Emergency Departments however, are inappropriately configured for managing mentally distressed people. As a result more appropriate psychiatric emergency facilities are being established in public hospitals. In New South Wales Psychiatric Emergency Care Centres (PECCs) have been established in some Emergency Departments in public hospitals to provide specialised mental health assessment and care at the crucial point of first contact with the

hospital. The units aim to provide high quality mental health interventions in a safe and supportive environment.

Ozhelp

Ozhelp is a programme funded through the National Suicide Prevention Programme to prevent suicide in the building and construction industry.

It aims to increase the awareness of suicide risk, to lessen this risk in an industry known to have higher rates of suicide, and to create referral pathways for those in the industry who need support and/or professional help to appropriate services.

Senate reference:

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

The ASPAC has defined the high risk groups set out below and is undertaking further research to further define those at highest risk of suicide.

There is little disagreement that the groups which are at high risk of suicide are the following: -

People living with mental illness – the need for a "chain of care"

This is the group with the highest risks for suicide.

Apart from the time of presentation the period of highest risk of suicide is in the transition out of 'treatment', usually from a facility, back into the community. To prevent suicide in this high risk period requires a "chain of care" to be established: follow-up after discharge from a mental health service, follow-up of crises as they present to EDs, GPs and in the community.

There is a need for community-based services, support and places for living. This is a problematic area for the Australian society as a whole with much of the burden of care being carried by non-government organisations.

Since the public mental health services are managed by the State and Territory Governments, the National Suicide Prevention Strategy and mental health programmes, such as those funded through the Council of Australian Government agreements need to negotiate with those governments and the managers of mental health services to achieve a "chain of care" in the management of people with mental disorders and illnesses.

People in rural and remote areas

The ASPAC has a working group to more clearly define the mental health and suicide risks in rural areas and to propose programs and projects relevant to the high risk rural areas and populations. It is unclear which groups are at highest risk and indeed the areas of highest risk. This project is being led by Professor Brian Kelly an acknowledged authority on rural mental health. (See attachments.)

Aboriginal and Torres Strait Islander people

The evidence is unequivocal that suicide rates are very high in Indigenous communities and that in young Indigenous males the rates are increasing.

Work in this area is being led by the Indigenous Strategies Working Group in cooperation with the Council. This group is chaired by Ms Adele Cox who is also a member of the National Advisory Council for Mental Health.

Clusters of suicide, especially those occurring in Indigenous communities, have led the Council to focus on the national response to suicide clusters.

A special project has been established to pursue this issue and to build on work done by Centres for Disease Control in the US. (See attachments.)

Men

In 2006, nearly 80% of suicides were in males. The ABS data for 2007/8 show the highest suicide rates are in men in the 40-44 year old age group (26.4/100,000).

Certain groups are at high risk - men in the building and mining industries, newly separated and older men and other groups such as Indigenous men, men in contact with the justice and corrections systems and the homeless. The aim is to target these groups - for example - projects to support apprentices (Ozhelp) and to promote older men's networks (the Older Men's Networks), with agencies in contact with newly separated men (for example, the Family Court and Centrelink) and men's sheds.

There are a number of projects specifically targeted to men and the ASPAC has made submissions and consulted with the Commonwealth Government's initiatives for Men's Health.

Young people

28% of suicides are in people under 30 years of age. The vulnerabilities to suicide develop in young people and it is important, therefore, to focus prevention on youth. *Headspace* is one example and *MindMatters* another. Telephone and web based support are important initiatives for young people, such as Kids Helpline and Reachout. But there are many other organisations which engage with young people at risk of suicide which are not conventionally seen as dealing with mental health problems and suicide; but in reality they do. Examples of such organisations are the Ted Noffs Foundation, Youth off the Streets, Triple Care Farm and Oasis in New South Wales and the Youth Substance Abuse Service and Turning point in Victoria to name a few examples.

Youth health centres and adolescent health units associated with children's hospitals and adolescent mental health units are important elements of support to youth who may be at risk of suicide.

MindMatters and KidsMatters Primary are examples of prevention of mental health problems and suicide risk through developing resilience and resourcefulness in schools. They aim to enhance well-being and safety at secondary and primary schools by ensuring that the school environment is supportive of mental health and that young people are protected against adverse mental health outcomes. A repertoire of resources for the classroom, assisting individual students with problems, engaging parents, defining pathways to care and for whole-of-school actions are made available in hard copy and through websites for teachers and school counsellors. These initiatives also support of the professional development of teachers. The importance of these initiatives is that they are run through the professional associations of teachers and have the commitment and interest of educational authorities (Principals Australia). MindMatters has received international recognition. Both MindMatters and KidsMatters have been positively evaluated. (Details are reported in the submission from the Department of Health and Ageing.)

People bereaved by suicide

Individuals and families bereaved by suicide need special support, and are also at higher risk of suicide themselves. There is a range of projects - the *Salvation Army Hope for Life Project,* the extension of *Standby* to several regions of Australia and the Jesuit Social Services – Support after Suicide programme in Victoria – are some examples. Other examples are the "***Standards & Guidelines for Suicide Bereavement Support Groups***" developed by Lifeline accepted as 'best practice' in the United States and the user friendly bereavement guidelines developed by SANE.

National conferences have been organised on 'postvention' bereavement support following suicide. No other country has given such priority to this area at a national level as has Australia.

People who have self-harmed or attempted suicide.

25-50% of people who take their own lives have previously carried out an act of self-injury. The *Access to Allied Psychological Services* program aims to provide specialist support for people who have self-harmed, attempted suicide or who have suicidal ideation. These services are supplemented by telephone call-back support to assist in the person's recovery.

This is a priority area for mental health services and especially for general health services such as Emergency Departments, specialised clinical services such as - drug and alcohol, pain, rehabilitation and geriatric clinics and especially in general practice and primary health care.

Senate reference:

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

A decade ago the National Health and Medical Research Council (NHMRC) had special funding for suicide prevention but suicide prevention has not been given priority by major research funding bodies. The Department of Health and Ageing submission details the level of funding by the NHMRC: between 2000 to 2009 for suicide and suicide prevention: it was equivalent to approximately 2% of all funding for mental health and 1.5% of funding for research into mental health and substance use combined.

Research in suicide and suicide prevention has generally depended on individual initiatives by academics in a range disciplines interested enough to do this type of research. Most research has been of an epidemiological nature and descriptive in approach. This is an area in which it is difficult to do intervention research and little has been done. In a separate submission to the Inquiry, Dr Jane Pirkis has advocated for a greater emphasis on intervention research.

The Australian Institute for Suicide Research and Prevention (AISRAP) at Griffith University is funded as a Centre of Excellence in Suicide Prevention Research. The AISRAP centre has been supported by the Commonwealth Government in its work with the *World Health Organisation's Suicide Trends in At-Risk Territories* project (WHO-START) in the Asia-Pacific region. (More detailed information can be found in the submission from the Department of Health and Ageing).

The Department of Health and Ageing has funded other studies such as a New South Wales case control studies through Sydney University in continuance of a National Health and Medical Research Council research grant; the Department has also funded a national research study of self-injury.

There has been some sociological research in Australia looking at groups and circumstances and comparisons between countries.

Senate reference:

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

Access to means of suicide

Possibly one of the most powerful areas for governments to act so as to prevent suicide is to lessen access to the means of suicide.

For example, by limiting access to toxic sedatives (barbiturates) and other agents (such as, paracetamol, organic fertilisers, and insecticides), controlling access to guns (The Gun Buyback Scheme) and carbon monoxide poisoning from a motor vehicle exhaust emissions.

Suicide from these causes has declined progressively over the last two decades and over a longer time period in the case of barbiturates.

Restrictions on barbiturates

The restrictions on the availability and prescribing of barbiturates have notably reduced the rate of suicide in females; barbiturates have been replaced by less harmful but never-the-less problematic tranquilisers and sedatives, namely, the benzodiazepine group of drugs.

The sentinel paper on barbiturates and suicide was published in the 70s by Professor Basil Hetzel and Dr Graeme Oliver from Monash University.[9]

Gun control

Gun ownership has declined since the “Gun Buyback Scheme” following the Port Arthur massacre: there have been no mass shootings since then, fewer homicides and reduced accidental and intentional firearm deaths.[10 11 12]

Motor vehicle exhaust gas – carbon monoxide.

During the 90s carbon monoxide poisoning by motor vehicle emission was a priority area in suicide prevention. Work was done at the Royal Melbourne Institute of Technology to develop a carbon monoxide sensor for the cabin of motor vehicles so as to shut off the vehicle’s engine before toxic/lethal levels of CO are reached.

Co-incidental with these developments the Australian motor vehicle fleet was changing to European standards for carbon monoxide emission. These events overtook the feasibility of introducing modifications to the design and manufacture of motor vehicles to include a carbon monoxide sensor and an engine shutdown system so the project lapsed.

In the event, the Australian car fleet has modernised to conform to the European standards resulting in a decline in suicides (and homicides) from motor vehicle gas emissions.

Alcohol and other drugs

Another area through which governments can directly influence the precursors of suicide is in the consumption patterns of alcohol in the population.

Alcohol

Varying degrees of alcohol intoxication can affect mental processes and decision-making; alcohol affects impulsivity and mood – both of which can increase the risk of suicide. Alcohol dependence has a high life-time risk of suicide of the order, if not higher, than in bipolar disorder and schizophrenia.

A longitudinal study of alcohol dependent subjects in the United States showed that conservatively estimated the risk of suicide in alcohol dependent persons is between 60 to 120 times of those not psychiatrically ill. In this study it was estimated that alcohol dependence contributes to 25% of suicides.[13]

Furthermore, international comparisons of epidemiological data show that countries with high alcohol consumption have (in general) higher rates of suicide.[14]

Governments have the power to use economic levers of taxation, and thus the price of alcohol, to affect overall alcohol consumption in the population; governments can exert control over the distribution and availability of alcohol through - licensing, hours of availability, locations of sales and drinking venues and the distribution and density of outlets in local areas; governments can control the way alcohol is advertised and promoted to vulnerable young people.

Other drugs and prescribed medications

Governments have roles to limit access to other substances – which increase the risks of suicide or are the direct cause of suicide through an overdose – opiates, hallucinogens, amphetamine type substances, cannabis, and prescription drugs such as sedatives, tranquilizers, paracetamol (an important anti-suicide measure in the United Kingdom) and other agents. Amongst these other agents are medications to treat depression, for example, the tricyclics antidepressants, as well as other conditions.

In a study of violent suicide deaths and homicides in New South Wales substances were detected in 65.5% and multiple substances in 25.8% of cases. Alcohol was present in 39.6% and illicit drugs in 23.9% of cases.[15]

Thus the measures to control the availability and access to a range of potentially toxic agents are important not only to manage the harms from alcohol and other drug abuse, they are also important measures to prevent self-harm and suicide.

General vs. specific interventions

As can be seen, suicide prevention is not a specific goal in many of these policies or strategies but it is an important outcome of these other health and social programmes.

Barriers to suicide prevention

The barriers to suicide prevention have to do with the ambivalence that exists in the community and in services and professionals in dealing with this issue.

There is a deeply ingrained view that mental health problems are too difficult and need special expertise. I would argue the opposite. Namely, that everyone can help others with mental distress and that it is the job of all health care and human service personnel to be able to respond in appropriate ways and to be open and empathic with distressed people. Such is the approach expressed through national suicide prevention and mental health promotion.

Secondly, there are long-existing taboos about suicide which influence the ability of this issue to be discussed openly between individuals and publicly.

At another level there is a reluctance to accept that suicide and suicidal thoughts reflect a mental illness and that individuals have the right to make decisions of this nature about their own lives. It is a deeply philosophical and moral question for some. These viewpoints are presented in a number of submissions made to the Inquiry.

For example, in *The London Review of Books,* Tim Parks in a review titled - *Stop It and Act* - of the book *This Business of Living: Diaries 1935-50* by Cesare Paves says, "Living …. is a trade you have to learn, and once learned, it must be sustained, with effort. Failure and humiliation are never far away. From the earliest pages, suicide is presented as a way of taking control of an existence that is slipping from one's grasp, not "a way of disappearing", but a positive statement. "Who knows," he asks, 'whether an optimistic suicide will come back to the world again?"[16]

I don't share these views but some people do, or have similar thoughts about suicide which are often recounted in literature and poetry. I note the Committee has had submissions about assisted suicide.

Suicide prevention at a community level is about social structures and cohesion of communities and the relationships of individuals to these networks and capacities. The French sociologist Durkheim saw suicide as an outcome of *anomie* – an alienation and marginalisation of individuals from the culture, work and purpose of communities. He compared different societies on the basis of their suicide rates.[17]

These issues are not dealt with by an instrumental approach but rather depend on wider social, economic and cultural factors which do not lend themselves to specific interventions.

Another barrier has been the failure to recognise that suicide risk goes beyond a paradigm of psychic pain and includes physical pain, social separation and attributions of failure and hopelessness perceived by the individual which may or may not be well-founded.

Prediction of suicide

The capacity to predict suicide in an individual case is poor. This means that human services and the community as a whole have to set the threshold of response to distress at a level so that suicidal people are not missed. In other words, it is better to have false positives than false negatives when engaging at the front-line with distressed people.

Chain of care

An essential component of the response to suicide prevention in emergencies is to establish a "chain of care". A chain of care means that each link in the transition from the immediate crisis - from one service/ agency to another, from one professional to another, has to be strong and well managed. The chain is only as strong as its links along the pathway to care and recovery.

Such pathways in the "chain of care' are supported by a funding programme through divisions of general practice. For those who present to an Emergency Department or to a general practitioner

who are at high risk of suicide there is the possibility of access through - *Access To Allied Professional Support* (ATAPS) – can be obtained to psychologists for immediate support. This project is currently being evaluated.

This is but one of many initiatives which are needed to ensure the safety of people with mental distress and illness. It is about transitions, communication and on-going shared responsibility. All governments and services should give the highest priority to this issue, not only in mental health, but in circumstances where there is a continuing need from continuing illness, disability and marginalisation.

The “chain of care” is important after all hospital admissions, attendance at clinics such as for pain, rehabilitation, drug and alcohol problems, disabilities and so on. It is also a key approach in primary health care and should extend as needed beyond a purely health service to other social services, supports and accommodation.

Ian W Webster AO

Emeritus Professor of Public Health and Community Medicine, The University of New South Wales

(Attachments)

Attachments:

Related funded mental health programmes

DOHA Mental Health Programs (from the Department of Health and Ageing)

Program Name	Description
Better Access to Psychiatrists, Psychologists and General Practitioners	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	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.
ATAPS Additional Support for Patients at Risk of Suicide and Self Harm	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 until 30 June 2010.
National Perinatal Depression Initiative	A 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	**Headspace,** the National Youth Mental Health Foundation, 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 non-Medicare Benefits Schedule incentive payments to community based general practices, private psychiatrist services and other appropriate organisations (such as Divisions of 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	This program aims to provide mental health support to individuals and communities affected by the Victorian bushfires by: • increasing 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; • increasing the capacity of increase telephone counselling services; • aiding 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 • delivering 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. *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 is part of the Australian Government's component of the COAG *National Action Plan on Mental Health (2006 – 2011)*. 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 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	This program is 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	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)	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 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 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.
The Mindmatters Initiative	The Mindmatters Initiative is the national mental health 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.

Current ASPAC actions and projects

(Notes derived from the ASPAC meeting 10th March 2010)[18]

NSPP Action Framework – summary of actions

Principle: Alignment and Leverage

- Through the Mental Health Standing Committee and the State and Territory Mental Health Directors agreement to develop an agreed National Framework for Suicide Prevention. The LIFE Framework to be the foundation document.
- The ASPAC will be invited to participate in this process.
- Each jurisdiction has or is developing a Suicide Prevention Strategy consistent with the LIFE Framework.
- At the Commonwealth level an initial meeting of the Mental Health Interdepartmental Committee commencing discussions on suicide prevention actions across government and to follow-up the report of the Senate Inquiry into Suicide.
- Arrangements in progress for ASPAC to engage with state and territory based suicide prevention councils.

Principle: Universal

- Continued support of media training and monitoring projects including
    - Coordination and facilitation of the National Media and Mental Health Group;
    - Coordination of a "data working group";
    - Consultation workshop with mental health organisations to discuss emerging and recent issues with suicide prevention reporting including data, youth suicide, cyber-bullying etc.
- On-going management of the suicide prevention Life Communications Project.
- Review of school based universal suicide prevention activities funded under the NSPP.

Principle: Selected and Indicated

- The National Centre of Excellence in Suicide Prevention reported on the relative suicide risk of suicide in different population groups to identify those at higher risk of suicide.
- The National Centre of Excellence in Suicide Prevention research project to identify groups at highest risk of suicide amongst people living in rural and remote Australia commenced.
- Extension of the Access to Allied Psychological Services (ATAPS) Additional Support for Patients at risk of Suicide or Self-Harm demonstration project.

Principle: National and Local

- State and Territory community based projects provided with continued funding for the period 2009-2011.

Principle: Evidence, Data and Evaluation

- Commencement of the process for the evaluation of National Suicide Prevention

ASPAC projects

Pathways to Care

The Pathways to Care Project to examine the mechanisms to respond to and provide care to people at imminent risk of suicide across Australia.

The ASPAC has engaged with the National Advisory Council on Mental Health (NACMH) and the Mental Health Standing Committee on this project and these bodies are represented on the project's reference group.

The Project's reference group consists of:

- (Chair) Ms Dawn O'Neil
- Ms Janet Meagher
- Ms Barbara Hocking
- Ms Wendy Sturgess
- Professor Neil Cole (NACMH)
- Dr Rob Walters (NACMH)
- Dr John Crawshaw (Mental Health Standing Committee)
- Ms Bronwyn Hendry (Mental Health Standing Committee)

Suicide Clusters and Suicide Hotspots (combined)

I has been decided that because of the similarities between the suicide hotspots and suicide clusters projects in terms of research, consultation and the production of a guidance paper applicable across Australia, that the two projects would be combined.

The management and execution of this project is being finalised.

Rural and Remote

The Rural and Remote Research Project aims to identify groups at highest risk of suicide amongst people living in rural and remote Australia.

The Centre of Excellence of the Australian Institute for Suicide Research and Prevention (AISRAP), Griffith University has agreed to undertake this project.

The methodology for the research project and is being finalised.

ASPAC focus on men and youth

ASPAC and its working groups are to commission and focus work on men and young people, with reference to the best evidence available and in particular, emphasis on men and young people living with a co-morbid mental health and alcohol and other drug condition, men and young people engaged with the justice system, and men and young people who are unemployed.

With the recent ABS data identifying the age group 40-44 years with the highest rates of suicide ASPAC will develop advice for action.

[1] United Nations (1996).s. United Nations, New York. *Prevention of Suicide: Guidelines for the formulation and implementation of National Strategies.*

[2] 1. Provide advice 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.

[3] Australian Bureau of Statistics 3303.0 Causes of Death Australia, 2008, page 47.

[4] Other data showing similar declines not included: prevalence of heroin, cannabis, amphetamines, inhalants, tranquilizer and sedatives, hallucinogens and injecting drug use.

[5] Pirkis J et al., Aust NZJ Psych, 2009; Johnson et al., Aust NZJ Psych, 2009.

[6] Kariminia A, Butler TG, Corben SP, Levy MH, Grant L, Kaldor JM and Laws MG. Extreme cause-specific mortality in a cohort of adult prisoners – 1988 to 2002: a data-linkage study. Int.J.Epidem. 36:310-316, 2007.

[7] Pirkis J, Blood RW, Dare A and Holland K. *The Media Monitoring Project: Changes in media reporting of suicide and mental health and illness in Australia 2000/01-2006/7*. Australian Government Department of Health and Ageing, Commonwealth of Australia, 2008.

[8] http://www.mhfa.com.au/program_overview.shtml

[9] Oliver G, Hetzel BS. An analysis of recent trends in suicide rates in Australia. *Int J Epidem* 1973; 2: 91-101.

[10]Ozanne-Smith J, Ashby K, Newstead S, Stathakis VZ and Clapperton A. Firearm related deaths: the impact of regulatory reform. *Inj Prev* 2004;**10**:280-286

[11] Leigh Andrew and Neill Christine, Weak Tests and Strong Conclusions: A Re-Analysis of Gun Deaths and the Australian Firearms Buyback (prepublished version) April, 2007

[12]Chapman S, Alpers P, Agho K and Jones M. Australia's 1996 gun law reforms: faster falls in firearm deaths, firearm suicides, and a decade without mass shootings *Inj Prev* 2006;**12**:365-372.

[13] Murphy GE and Wetzel RD, The lifetime risk of suicide in alcoholism. Arch Gen Psychiatry, 47(4): 383-392, 1990.

[14] Lester D, The association between alcohol consumption and suicide and homicide rates: a comparison of 13 nations. Alcohol, 30(4), 465-468, 1995.

[15] Darke S, Duflou J and Torok M. Drugs and violent death: comparative toxicology of homicide and non-substance toxicity suicide victims. Addiction, 104, 1000-1005, 2009.

[16] Parks Tim, Stop It and Act book review of This Business of Living: Diaries 1935-50 by Cesare Pavese, translated by AE Murch London Review of Books Vol 32 No 3 11 February 2010 pages 7-10.

[17] Durkheim Emile, *Le Suicide*, 1897.

[18] Adapted from briefing notes for Australian Suicide Prevention Advisory Council 10th March 2010