The Royal Australian & New Zealand College of Psychiatrists

Submission to the Senate Community Affairs References Committee:

Inquiry into Suicide in Australia

November 2009

working with the community

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Executive Summary

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) is pleased to have the opportunity to make a submission to the Inquiry into Suicide in Australia aimed at reducing the number of people who die from suicide. The RANZCP is committed to improving the outcomes of people who may have attempted or who are at risk of suicide and commends the Government for conducting this Inquiry.

Addressing the incidence of suicide in Australia requires strategies to critically address the factors that contribute to and perpetuate suicide. There is consistent evidence to support the finding that people who die by suicide have a much higher prevalence of mental illness than the general population. Serious mental illness such as depression, substance abuse, anxiety disorders and schizophrenia are strongly associated with increased risk of suicide. This submission particularly focuses on the interaction of suicide and mental illness and the strong correlation between these two issues.

This submission focuses on the key priorities for attention in suicide prevention, particularly as they relate to mental illness. The RANZCP has made a number of recommendations and looks forward to contributing further to this process as it develops.

Key messages from the RANZCP regarding suicide prevention are:

- Suicide prevention research programs must be coordinated at the highest level with strategic leadership to ensure effective outcomes.
- The development of a cross sector suicide reporting system that is easy to use and allows accurate data reporting is essential.
- Community and practitioner mental health literacy should be improved through the use of education programs aimed at identification of, and support for, those at suicide risk.
- Health service availability, accessibility and navigability for those who require mental health support needs to be improved.
- An increased number of aligned national public awareness programs and specific targeted programs for those at risk, with a strong focus on the evaluation of the effectiveness of such programs are required.
- Specific systematic interventions are required to address the needs of those at greatest risk including: adolescents; older persons; those who self-harm; suicide survivors; those transitioning between mental health care services; those in rural areas; Indigenous Australians; those who misuse alcohol or drugs; refugees and asylum seekers; and the families and carers of suicide victims.

For further information in respect of this submission or to schedule a meeting, please contact:

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Summary of Recommendations

In response to the terms of reference of the inquiry, the RANZCP makes the following recommendations.

a) the personal, social and financial costs of suicide in Australia:

1 Funding allocated to suicide prevention should be equivalent to that spent on events and/or illnesses with a similar death rate – for example breast cancer.

2 A comprehensive study is required in Australia to reach a better understanding of the costs and demographics of suicide.

b) the accuracy of suicide reporting in Australia, factors that may impede accurate identification and recording of possible suicides:

3 Improvements to the system of national suicide reporting are required to ensure consistent, accurate, reliable, and timely reporting. This will require:

   (i) Increased resources and funding to achieve agreed criteria for suicide reporting across the sector.

   (ii) Improved breakdown of suicide rates for high risk groups and by ethnicity.

4 Coroners, clinicians and those bereaved by suicide should collaborate to develop criteria for making a determination on suicide that reduces stigma.

c) 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:

5 Training, education and support should be provided for frontline staff - i.e. health care professionals, service providers, school teachers, family, friends, and the wider community – to recognise and assist people who are experiencing a suicidal crisis.

6 Improvements and enhancements of mental health literacy within gatekeeper and community organisations are required.

7 Minimum standards should be developed for how authorities, in particular the police, report suicide or attempted suicide.

8 Systemic issues need to be addressed to improve risk assessment and management in health care, in particular mental health care, including an improved and timely crisis response to those people presenting as mentally ill and/or acutely suicidal.

d) the effectiveness, to date, of public awareness programs and their relative success in providing information, encouraging help-seeking and enhancing public discussion of suicide:

9 Further research, evaluation and analysis into the effectiveness of suicide prevention public awareness campaigns is required and could be led by the National Health and Medical Research Council.

10 Suicide awareness programs that avoid stigmatising or sensationalising suicide in an appropriate manner should be developed through consultation with community groups.

e) the efficacy of suicide prevention training and support for front-line health and community workers providing services to people at risk:

11 Clinical outcomes, rather than the education process, of suicide prevention training need to be evaluated.

12 Ongoing education regarding identification and appropriate treatment of the different types of depressive disorder should be provided to General Practitioners in particular. General Practitioners should be expected to provide evidence at set intervals that they have given attention to such training.

13 Those training at all medical schools or undertaking training as other health professional should be given suicide prevention education to ensure good literacy in general physicians and health care professionals early in their careers.

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

14 Increased numbers of appropriately trained health professionals to provide general and mental health care to high-risk groups are required. This would be supported by additional funds for training and support of first responders (i.e. ambulance, police, and fire brigade) to suicide attempt survivors; and improved integrated systems of advice and support for these agencies.

15 Access to means of suicide needs to be reduced through specific legislation to reduce access to paracetamol.

Adolescent suicide

16 Specific suicide prevention strategies are required for adolescents, including for suicide attempters. Further research into these strategies is required to ensure that they are effective and that they can be readily used in a broad range of settings.

Old age suicide

17 Collaboration across governments is required to develop a strategy for older Australians to have adequate access to specialty mental health and dementia care services.

18 Primary or Universal Suicide Prevention in Old Age should be part of a Healthy Ageing Health Promotion Strategy. Any strategy that will improve the health of people in old age will be consistent with reducing late life suicide.

19 Secondary or Selective Suicide Prevention strategies should focus on those at high risk (e.g. older people with chronic pain, socially isolated migrants & rural elders, older persons with a history of depression, older persons recently diagnosed with life-threatening illnesses such as cancer or dementia) by training gate keepers about the risk and ways of reducing it.

20 Tertiary or Indicated Suicide prevention should focus on detection of depression and suicide risk in older individuals. More training should be provided for GPs and other health professionals to assist them in identifying potentially high risk individuals and understanding how to better treat depression in those individuals identified.

21 To particularly address the risk of suicide in men in Australia aged over 75 there is a need to:

(i) Research and evaluate attitudes towards euthanasia among older Australians.

(ii) Enhance and impart knowledge about the availability of palliative care and other interventions that reduce perceived burdens on older males and persons closest to them caused by disabling and distressing physical conditions.

(iii) Focus on the special needs of older men who are isolated or disabled and need attention, with a particular focus on older men's psychological health (e.g. by using Men's Sheds).

People who self-harm and suicide survivors, and people transitioning in and out of specialist mental health care

22 Assistance should be provided to people transitioning in and out of specialist mental health services, suicide attempt survivors, and those who self-harm, by offering post-discharge support, particularly for casualty and psychiatric patients. This must include funding and support for interventions that maintain contact and follow-up after the event.

23 The Victorian 'No wrong door policy' of access to services should be introduced Australia-wide.

Indigenous and rural communities

24 An increase in the number of community services that can provide holistic longer term care for Aboriginal and Torres Strait Islanders that are proficient in recognising mental health issues. The Commonwealth government should invest in mental health generally and suicide identification and prevention specifically for Indigenous populations.

25 Greater incentives should be provided for mental health practitioners to live and practice in rural areas, including access to peer support and continuing professional development opportunities.

Other socially disadvantaged groups (including refugees and asylum seekers)

26 Culturally appropriate services for asylum seekers and migrants should be provided to ensure mental wellbeing. These services should be available both in cities and in detention centres.

Alcohol and substance users

27 Access for clinicians to share their clinical expertise in key community sectors should be increased, such as the alcohol and other drug sector, especially in non-acute settings (in order to reduce hospitalisation rates).

28 Investment in more specialised dual diagnosis (alcohol/drugs and mental health) beds and services across Australia is required.

Families and carers of suicide victims

29 Provisions should be made available for people that experience the loss of a family member under the traumatic circumstances of suicide to access immediate support services.

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

30 Collaboration is required between Federal and State governments in regard to funding research in suicide prevention, including the appointment of a properly constituted expert body to oversee all research into suicide prevention that is linked formally with academic institutions.

31 All suicide prevention strategies should be properly evaluated with at least 15 per cent of all funding allocated to suicide prevention strategies being spent on evaluation.

32 Further research into clinical practices such as increasing staff observations of suicidal patients, hospital admissions, and psychiatric therapies and its effect on suicidal risk should be undertaken.

33 Research into effective suicide prevention strategies for older populations should be undertaken.

34 Research and funding for projects into the lived experiences of suicide attempt survivors should be undertaken.

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

35 There should be systems developed to review and monitor the National Suicide Prevention Strategy with a commitment to evaluation and publication of data reflecting the effectiveness of programs.

36 Improved understanding of the lived experience of suicide attempt survivors in all suicide prevention efforts is required, including a stronger focus on incorporating the views and experiences of suicide attempt survivors in the policy, research and development of mental health services and in the development of interventions (and evaluation) for suicide prevention.

1. About the RANZCP

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) is the principal organisation representing the medical specialty of psychiatry in Australia and New Zealand and has responsibility for the training, examining and awarding the qualification of Fellowship to medical practitioners. There are approximately 3000 Fellows of the RANZCP who account for approximately eighty-five per cent of all practicing psychiatrists in Australia and over fifty per cent of psychiatrists in New Zealand. There are branches of the RANZCP in each state of Australia, the ACT and New Zealand.

Through its various structures, the RANZCP accredits training programs and administers the examination process for qualification as a consultant psychiatrist; supports continuing medical education activities at a regional level; holds an annual scientific congress and various sectional conferences throughout the year; publishes a range of journals, statements and other policy documents; and liaises with government, allied professionals and community groups in the interests of psychiatrists, patients and the general community.

The RANZCP is a leader amongst Australasian medical colleges in developing partnerships with consumers and family and other carers in respect to excellence of service provision. The Board of Practice and Partnerships includes consumer and carer representatives from a variety of backgrounds who contribute extensively to the development and management of RANZCP programs and activities, and works together with the community to promote mental health, reduce the impact of mental illness on families, improve care options and supports, and ensures that the rights of people with mental health concerns are heard by mental health professionals.

To develop its response to this Inquiry, the RANZCP set up an expert panel consisting of the following Fellows of the College:

Professor David Copolov

Professor Diego De Leo

Professor Brian Draper

Dr Michael Dudley

Dr Julian Freidin

Professor Robert Goldney

Dr Simon Hatcher

Associate Professor Malcolm Hopwood

Professor Graham Martin

Dr Nicholas O'Connor

Associate Professor Geoff Smith

Professor John Snowdon

Professor Garry Walter

2. About Suicide and Mental Illness

Suicide is a leading cause of death for people around the world. Globally, approximately 1 million people die by suicide each year including nearly two thousand Australians, greatly impacting families, friends, workplaces and communities. Suicide has biological, cultural, social and psychological risk factors. The connection between mental disorders and suicide is particularly strong. Serious mental illness such as depression, substance abuse, anxiety disorders and schizophrenia are strongly associated with increased risk of suicide. Even with good treatment delivered by quality services, mental illness can be fatal. Regrettably, suicide can be a consequence of severe mental illness. The RANZCP recognises that it is devastating for families to lose anyone to suicide and psychiatrists are committed to reducing this death toll by providing best available psychiatric care.

Mental illness is one of the most common and significant contributing factors to suicide in Australia. It is estimated that about two-thirds of those who die by suicide have symptoms consistent with major depression at the time of death [1]. The 2007 National Survey of Mental Health and Wellbeing showed that people with a mental illness are much more likely to have had serious suicidal thoughts than other individuals (8.3 per cent compared with less than 0.8 per cent). Almost three-quarters of the survey's respondents who had had serious thoughts about suicide had a mental illness [2]. If the person was experiencing suicidal thoughts or behaviours as part of their mental health problems they were more likely to access services, however a significant proportion did not receive treatment. It is important to note that, while mental disorders are present in the majority of suicides, a significant number (estimated to be more than 80 per cent) were untreated at the time of death [3]. References to mental illness in the context of suicide prevention research typically relate to *identified* mental illness, although those who die from suicide and have non-identified or untreated mental illness should not be excluded.

Mental disorders are responsible for an estimated 11% of disease burden worldwide (thought to increase to 15% by 2020) [4]. Projections suggest that the mental health related disease burden will grow markedly as a proportion of overall disease burden [5]. This issue places significant pressure on mental health services which are not adequately resourced to deal with disorders, particularly those at the more severe end of the spectrum. The Australian Government's investment over the last few years has provided a significant boost to the mental health system, however the RANZCP believes that the overall investment in the mental health service system remains inadequate and does not reflect the burden of disease in the community. A significant increase in funding to the mental health sector is required so that available resources are proportionate to the increasing number of people with mental illness. Progress in remedying this situation is slow and lack of these services may be contributing to suicides.

Currently, there are no standardised service models within the mental health service system in Australia, with levels of care varying significantly across the country. The different governance structures further complicate service delivery issues. Service delivery would be improved with the development of a single integrated health system, the removal of structural barriers at the State and Australian Government levels, and with substantial reform in both. The RANZCP welcomes the National Health and Hospital Reform Commission report [6] and the attention it gives to prioritising mental health as a key reform direction, however we believe that there is still a long way to go. To help prevent suicide, further investment must be made in the prevention, identification and appropriate treatment of mental illness for people in Australia including increased and improved workforce, research, consumer involvement, and funding. Services should be accessible and easy to navigate. If people attend an agency that may not service their needs directly, they must be able to receive guidance regarding engaging with a service that can assist.

Suicide prevention strategies must be aimed at addressing the relationship between mental illness and suicide with a focus on appropriate identification, promotion, prevention, and treatment options, highlighting that mental illness is frequently treatable. Improved mental health literacy, matched by improved accessibility to mental health services and collaborative initiatives that encourage a reduction in stigma and an increase in help-seeking, remain central to minimising the risk of suicide and self-harm among mentally ill individuals. Adequate consideration should be given to suicide attempts and this should specifically target those at elevated risk, particularly those with mental disorders [7]. Some of these interventions need to be clinically-oriented, and should involve ensuring that clinicians are able to detect, diagnose, assess and manage suicidal risk, especially in people with mental disorders. Other interventions should be population-based and should draw on sectors outside health to reduce known risk factors [7].

Although many people who take their own life are not in the care of mental health services, many will have seen a health practitioner in the time leading up to their death. Psychiatrists have a critical role in overseeing the issues that surround advice on suicide; both in the education of other professions about mental illness including identifying risk factors that may lead to suicide, and in monitoring and advocating for service responsibility and improvement. However, as suicide is linked to a broad range of psychological and social factors, psychiatrists and other mental health professionals may not always be placed to advise or offer assistance to prevent suicide in individuals. This highlights the need for general improvement of mental health literacy for all practitioners, agencies, and community groups in identifying the risk factors, and carrying out further action as appropriate.

There is a need for better coordination of the activities of the National Mental Health Strategy and the National Suicide Prevention Strategy to help achieve the aim of getting more people with mental disorders and suicidal behaviours into appropriate treatment [8]. In regard to suicide and mental illness, there are times of specific and great risk; points of transition in care are particularly important. Providing better continuity of care and monitoring transition between care services is an essential part of this process. The management of this care should be undertaken by multi-disciplinary teams led by psychiatrists. There is a further need to focus on improved management of depression in primary care to prevent more serious mental illness from developing.

3. Response to the Terms of Reference of the Inquiry

In responding to this inquiry, the RANZCP has addressed each of the terms of reference of the inquiry consecutively. The RANZCP recognises and appreciates the work which the Australian Government has undertaken in regard to the National Suicide Prevention Strategy. The Living Is For Everyone (LIFE) Framework developed under the National Suicide Prevention Strategy includes a range of strategies which the RANZCP fully supports. In addressing the terms of reference of the Inquiry the RANZCP focuses on the development of specific strategies to advance the issues unique to mental illness and its association with suicidal behaviours which it believes will enhance the work already being undertaken in this area.

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

a) the personal, social and financial costs of suicide in Australia;

The personal and social cost of suicide has both immediate and far reaching effects on families and communities. It is estimated that each suicide seriously impacts at least six other people [9, 10]. No estimates exist in Australia of the substantial human, social and economic costs of suicide and self-harm. In California the cost of individual suicide based on costs incurred by individuals, families, employers, government programs, insurers and tax payers has been calculated as $4,781 (US) for the average medical cost and more than $1.2 million (US) for the average lifetime productivity loss. The average medical cost per hospitalisation for a suicide attempt was more than $12,000 (US), and the average work-loss per case was over $14,000. All together this equates to costs of approximately $4.2 billion (US) per year [10].

With regard to death rates, the Australian Bureau of Statistics data on suicide deaths for 2007 compared with deaths from breast cancer, skin cancer, and land transport accidents are set out in Table 1 [11]. However the National Health and Medical Research Council disease and health issues expenditure summary from 2008 clearly shows that considerably less was granted to research into suicide and self-harm when compared to the other disease areas mentioned. Despite not including research spent on general mental disorders, this still remains comparably very little. The RANZCP recommends that funding for suicide prevention and research should be comparable to funding spent on illnesses with a similar death rate.

Table 1

	Suicide	Breast cancer	Skin cancer (including melanoma)	Road traffic accidents
Death rates (Australian)	1,880	2,706	1,727	1,273
Research expenditure ($m)	$790,786	$17,482,128	$9,253,307	N/A

It is estimated that at least 10% of patients with schizophrenia, major depression and bipolar disorder will die from suicide. This is frequently, if not inevitably, regarded as a failure of care that would have been

prevented had the quality of care been higher. The focus of a range of external bodies and statutory authorities on negative clinical outcomes is inherently unbalanced and has become a major distraction. Suicide is a regrettable fatal consequence of mental illness and, whilst there is a need for better detection, there is also a need to move away from the culture of blaming and instead focus on ways to improve the care that individuals receive. It is important to recognise that some suicides, particularly for those suffering mental illness, are preventable and that whole system improvement is necessary to aid prevention. It is vital that consumers are able to easily access and navigate services to ensure that people get the right service at the right time.

Recommendations:

1. Funding allocated to suicide prevention should be equivalent to that spent on events and/or illnesses with a similar death rate – for example breast cancer.
2. A comprehensive study is required in Australia to reach a better understanding of the costs and demographics of suicide.

b) 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);

Accurate statistics provide the foundation for appropriately targeted prevention strategies and research and understanding the full costs of suicide. Without reliable data, the effectiveness of suicide prevention strategies is not detectable. It is therefore vitally important to ensure that there is accuracy in suicide reporting. Additionally, there is also a need for improved data on self-harm, and how this interacts with suicide data.

There is a general acceptance that deaths from suicide are under-reported. Available evidence often leaves the cause of death uncertain, for example single vehicle road crashes. Without positive evidence, investigators cannot determine whether suicide or other factors are the cause. However, intentional self-harm (ISH) was found in 39 percent of coronial cases for 2005-07 with undetermined intent. In Australia, current research has determined that national suicide under-reporting probably grew from 2002 to 2006 [12]. Figures for undetermined intent deaths compared to suicide deaths from the Australian Bureau of Statistics (table 2) indicate that while the suicide death rate decreased from 4778 to 1799, the number of undetermined intent deaths was essentially unchanged.

Table 2

	Suicide deaths 2001/2	**Undetermined deaths 2001/2**	**Suicide deaths 2006**	**Undetermined deaths 2006**
Total	4778	137	1799	135

The 2006 figures of undetermined deaths are comparable proportionally with figures from 1975/6. Further investigation about the reasoning for this pattern is necessary. Whilst the increase in undetermined intent death rates compared to suicide deaths does not account for the total drop of reported suicide rates in Australia, it may be a contributing factor.

There are a number of systemic reasons for difficulty in reporting accurate national suicide figures, including: the absence of a central authority for recording and reporting mortality data; data is collected for different purposes by multiple parties with different standards of proof and reporting timelines; there are inconsistent coronial processes for determining intent due to inadequate information inputs, suicide

stigma, and high standards of proof; there are problematic collection and coding methods for data stakeholders; and there is lack of systemic resourcing, training and shared expertise.

The lack of information in death records on some characteristics of people dying by suicide further contributes to the ignorance of suicide risk factors and distribution. Evidence shows for example that Indigenous Australians aged 12-24 have suicide rates four times greater than non-Indigenous [13], but where non-reliable data under-identifies Indigenous status, this can hamper measurement and analysis. Further gay, lesbian, bisexual and transgender status is seldom recorded despite these groups' over representation in suicide and self-harm [14]. Stigma associated with suicide may have an effect on coronial reporting. From a public health perspective, social stigma about suicide and self-harm must be tackled if widespread under-reporting is to stop. As part of the process to improve reporting, families bereaved by suicide must be involved in helping to reduce the stigma associated with it.

Even allowing for under-reporting, there does appear to have been a reduction of suicide in recent years and systematic studies do suggest that official figures provide a valid basis for broad comparison [15]. Whilst this is encouraging, the RANZCP believes that there is a need for improved national suicide reporting universally to ensure that figures are as accurate as they can be. The RANZCP strongly supports improved consistency and reliability of serious event reporting, and the rigorous review of serious events. With better systems of reporting, the full extent of the potentially serious consequences of mental illness can be analysed and preventable deaths avoided through improved strategies.

***Recommendations**:*

3 Improvements to the system of national suicide reporting are required to ensure consistent, accurate, reliable, and timely reporting. This will require:

   (iv) Increased resources and funding to achieve agreed criteria for suicide reporting across the sector.

   (v) Improved breakdown of suicide rates for high risk groups and by ethnicity.

4 Coroners, clinicians and those bereaved by suicide should collaborate to develop criteria for making a determination on suicide that reduces stigma.

c) 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;

Of people who seek help for a mental disorder in Australia, 77% consult their general practitioner [4]. In the United States, 83 per cent of those who have died from suicide have had contact with a primary care physician within a year of their death and up to 66 percent within a month [16]. Emerging evidence indicates that these figures are comparable in Australia. It is further estimated that about two-thirds of those who die by suicide have symptoms consistent with major depression at the time of death [1]. It is therefore important that there is integration and coordination of services at primary, secondary and tertiary care levels. Thus, a key prevention strategy is improved screening of depressed patients by primary care physicians and better treatment of major depression.

Suicide prevention is not limited to health services. Suicide prevention includes a range of interventions focused on community or organisational gatekeepers whose contact with potentially vulnerable populations provides an opportunity to identify at-risk individuals and direct them to appropriate assessment and treatment. There is a need for much improvement in the role of these gatekeepers in the prevention of suicide. Improving people's knowledge of mental illness can lead to a greater

recognition and understanding of mental health, increased help-seeking and support [17], and educating those who are most likely to come into contact with people with mental illness can increase community support and lead to early intervention and prevention. Gatekeepers include clergy, first responders, pharmacists, geriatric caregivers, personnel staff, and those employed in institutional settings, such as schools, prisons, and the military [16]. Relevant interventions include awareness of risk factors, policy changes to encourage help-seeking, availability of resources, and efforts to reduce stigma associated with help-seeking. In addition to gatekeeper training, programs are required to promote organisation-wide awareness of mental health and suicide, and facilitate access to mental health services. There is generally evidence that gatekeeper training is effective, important and relevant. However, to date, systematic evaluation of gatekeeper training on suicidal behaviour has largely been limited to multilevel programs conducted in institutional settings, such as the military where programs in the Norwegian Army and the US Air Force have reported success in lowering suicide rates [16].

Agencies often report that they are given responsibility for mental health work that they are unable to discharge. In emergency departments acutely suicidal persons can be made to wait for inappropriately long periods of time before being seen. Suicidal persons in emergency wards are a unique group as interventions are required to address the psychological and emotional needs, as well as any physical consequences. Emergency wards need to be able to respond appropriately and rapidly to psychological distress. An Australian study reported that about one third of suicide attempt survivors described their satisfaction with their hospital treatment as 'mixed' and one fifth as 'poor' or 'very poor'. Similarly, 28 per cent of suicide attempt survivors described the attitudes of health care professionals in the hospital environment as 'mixed' and 33.5 per cent as 'poor' and 'very poor' [18]. RANZCP welcomes the National Health and Hospital Reform Commission report [6] recommendation that all acute mental health services have a 'rapid response outreach team' (known in some states as Crisis and Assessment Teams). Having these teams available 24 hours a day to urgently assess a person experiencing a mental health crisis and provide required short-term treatment, before the person is connected back in with ongoing management and support, may be critical to preventing suicide among those who are mentally ill.

In addition to providing care within a hospital setting, there is a need to better understand the work of teams that first respond. Anecdotal evidence suggests that the presence of police during a suicidal crisis can be problematic for those experiencing a suicidal crisis. Currently, there is limited information about first responders in an Australian context; who they are, what their training is, and what impact their behaviours can have on future help-seeking. However, there is some suggestion that if first responders (i.e. police, ambulance officers and fire brigade) act with compassion and empathy towards suicide attempt survivors, this can make a difference in their recovery [19]. The effect of dealing with high intensity and high risk situations on those individuals cannot be ignored and appropriate training is essential.

***Recommendations**:*

5. Training, education and support should be provided for frontline staff - i.e. health care professionals, service providers, school teachers, family, friends, and the wider community – to recognise and assist people who are experiencing a suicidal crisis.
6. Improvements and enhancements of mental health literacy within gatekeeper and community organisations are required.
7. Minimum standards should be developed for how authorities, in particular the police, report suicide or attempted suicide.

8 Systemic issues need to be addressed to improve risk assessment and management in health care, in particular mental health care, including an improved and timely crisis response to those people presenting as mentally ill and/or acutely suicidal.

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

Although literature demonstrates that public awareness campaigns addressing suicide prevention do not have strong evidence of effectiveness, a low base rate of suicide figures makes the effectiveness of suicide prevention strategies difficult to analyse. There is an equal lack of evidence demonstrating that public awareness campaigns are counterproductive [16]. Until there is sufficient evidence and analysis of these programs, it is not possible to make a determination on effectiveness. The RANZCP supports further research in this area.

Whilst there are some good campaigns that focus on suicide prevention, these are rarely supported by meaningful ongoing community supports other than crisis telephone lines. Awareness campaigns should not only focus on prevention, but also increase community awareness regarding treatment and support options, including the role of different mental health practitioners, in order to be beneficial for consumers, carers and their families.

A number of Australian and international studies have considered the social impact of media reports on suicide and mental health or illness. Research suggests that in certain circumstances reports about suicide can lead to imitation or 'copycat' suicide attempts by vulnerable people in the community. Therefore care should be taken to report the issues in a sensitive way and to ensure that accurate information is given [20]. Although the reporting of suicide has been linked to increased suicide rates, there is also evidence that suicide being reported in a sensitive manner may reduce suicide rates, particularly when the emphasis is on suicide as a tragic and avoidable loss, avoiding sensationalising or glorifying coverage with excessive details, and includes discussion of sources for help.

Media reporting is of particular concern for school-age children who are especially vulnerable to media influences. Australian reporting has demonstrably improved in response to media reporting guidelines [21, 22]. However, increases in awareness have not necessarily translated into increased willingness to seek help [2]. Concerns about inappropriate media reporting and public discussion about suicide, must be balanced against the costs of silence about a major social problem. Although anti-stigma campaigns for mental health have been developed in recent years, de-stigmatising self-harm and suicide remains controversial. Suicide should be able to be discussed without fear and, as part of public awareness programs, there is a need for debate on how to talk about suicide. This includes the need for those bereaved through suicide, and also suicide attempt survivors, to talk openly about their experiences.

***Recommendations**:*

9 Further research, evaluation and analysis into the effectiveness of suicide prevention public awareness campaigns is required and could be led by the National Health and Medical Research Council.

10 Suicide awareness programs that avoid stigmatising or sensationalising suicide in an appropriate manner should be developed through consultation with community groups.

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

While low base rates of suicide make it difficult to determine and evaluate the outcomes of suicide prevention, whole-of-community and national approaches to suicide prevention can demonstrably work [23]. There is some evidence that suggests that such training is effective. The efficacy of suicide prevention training should be evaluated to demonstrate firm evidence of which training packages are likely to help and produce positive outcomes. At present, much of the focus of evaluation is on the training process rather than the clinical outcomes. Whilst it is useful to demonstrate information can be learnt, further research into the translation of training to the actual outcome of preventing suicide is necessary. For example, Lifeline has demonstrated that training people can enhance capacity to deliver suicide prevention through telephone counselling.

As most suicide victims are seen by a General Practitioner within three months of their death [16], there is a need for improved identification and enhanced management of depression in primary care to prevent more serious mental illness from developing. This should include liaison with other community groups, social workers and through environmental interventions. A study in Gotland, Sweden [24] demonstrated the beneficial effects of GP education in relation to suicide rates, and the corresponding deleterious effect of withdrawing ongoing education. A distance education program in Australia has been developed for this purpose and widespread implementation of similar programs is supported [25].

Recommendations:

11 Clinical outcomes, rather than the education process, of suicide prevention training need to be evaluated.

12 Ongoing education regarding identification and appropriate treatment of the different types of depressive disorder should be provided to General Practitioners in particular. General Practitioners should be expected to provide evidence at set intervals that they have given attention to such training.

13 Those training at all medical schools or undertaking training as other health professional should be given suicide prevention education to ensure good literacy in general physicians and health care professionals early in their careers.

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

Targeted programs and services must address the particular circumstances of high risk groups. Additionally, there is a need to decrease risk factors in the general population. Ensuring the good mental health of the whole population will naturally lead to a reduction in suicide rates and there are a number of ways this can be achieved, including improved social interaction and through improved access to services.

Providing well integrated services to a population with widely differing and complex needs is inherently difficult and resource intensive. However, the alternative is likely to be a set of interventions that focus on symptomatic rather than causal factors which perpetuates service gaps, cost shifting pressures and ineffective commitment of resources. The call for greater collaboration between all levels of Government, between services at each level of government and with the community sector is welcomed.

Availability of the means of suicide is also of high significance to suicide rates. Public health approaches (planned or unplanned) aimed at decreasing the availability of lethal, culturally accepted methods of suicide have resulted in an overall decline in suicide rates. The RANZCP supports continued reduction to access to suicide means.

***Recommendations**:*

14 Increased numbers of appropriately trained health professionals to provide general and mental health care to high-risk groups are required. This would be supported by additional funds for training and support of first responders (i.e. ambulance, police, and fire brigade) to suicide attempt survivors; and improved integrated systems of advice and support for these agencies.

15 Access to means of suicide needs to be reduced through specific legislation to reduce access to paracetamol.

The RANZCP has identified the following priority groups for targeted programs and services based on the high incidence of mental disorders within these populations:

Adolescent suicide

Suicide rates rise through the teen years and into the 20s. Suicides under the age of 14 are not reported in Australia, although such deaths can be frequent, especially in Indigenous communities. For youth aged 15-24 years, suicide accounts for 20% of deaths [26]. Suicide risk factors and processes often extend back to early childhood. Psychological, biological, and illness-related factors interact with family, school and wider socio-cultural environments.

For youth suicide prevention, school-based programs are important and can include suicide awareness, skills training, screening, peer support and gatekeeper training, although there is a mixed level of evidence about the effectiveness of these programs [27]. Generally, using a combination of universal approaches to improving mental health and promoting help-seeking behaviour, and selected and indicated programs (e.g. screening, case-finding and anti-bullying referral programs) is most likely to be effective.

Adolescent suicide attempters are another high risk group that require specific attention. A study to assess the feasibility of systematically treating depressed adolescents who had recently attempted suicide demonstrated that allocation to Cognitive Behavioural Therapy, medication, or the combination lowers the 6-month risk for suicide events and reattempts [28]. Further research and evaluation in this area is necessary.

***Recommendations**:*

16 Specific suicide prevention strategies are required for adolescents, including for suicide attempters. Further research into these strategies is required to ensure that they are effective and that they can be readily used in a broad range of settings.

Old age suicide

Primary care and mental health workers need to be aware of the special needs of older people, particularly men. Statistics regarding suicide rates in Australia dispel the widely held belief that suicide is primarily a problem among young people. Despite reductions in suicide rates over the last few decades, the number of suicides among older age groups can be expected to rise, given that they constitute the fastest growing segment of the population. Suicide rates reach a second peak (after the 25-44 age group) in older men aged over 85 years. Men aged 75 years and over remain a high risk group. Contributing factors in old age suicide may include physical or economic dependency, mental and/or physical health problems, chronic pain, grief, loneliness, alcoholism or carer stress.

Older men in rural areas have a particularly high risk especially in circumstances of drought, poverty and lack of a younger generation for support. Older migrants from some cultural backgrounds (e.g. Eastern Europe) where isolation is accentuated due to an absence of compatriots are at high risk. Suicide is likely to be under-reported in the elderly with GPs and other doctors being inclined to record deaths in elderly as being due to natural causes to avoid stigma for families, or possibly in some circumstances to cover up assisted suicides.

The majority of older suicides have a mental disorder at the time of death, usually severe depression. Suicidal older people are more difficult for doctors to detect than younger persons at suicide risk even though they are very likely to consult a GP in the months before death. They are less likely to discuss suicidal thoughts, have fewer immediate life events, and have more chronic disorders.

GPs acknowledge that they have difficulty in detecting depression in late life, lack confidence in treating it, and that this is a training need that remains inadequately met [29]. Older people are less likely than younger adults to be referred for specialist mental health treatment. Factors that might contribute to this include stigma, ageism and lack of appropriate old age mental health services especially in rural and regional Australia. The recent National Health and Hospital Reform Commission report highlighted this deficiency and recommended collaboration of governments to develop a strategy for older Australians to have adequate access to specialty mental health and dementia care services.

The pattern of psychiatric diagnoses among older people who kill themselves is often different to the pattern observed in younger people. The circumstances leading up to a suicide attempt in old age frequently involve declining health including chronic pain, in combination with social isolation, lack of social support, and evolving depression and hopelessness. Late life suicide prevention should be about a 'whole of life' philosophy. Training of health professionals should emphasise the importance of communication with family and close friends and vice versa. Recent research [30] has found that often concern about suicidality in the weeks before suicide that was not adequately assessed due to a lack of communication between families and health professionals. Of particular importance in the suicide risk group of older men is the concept of 'rational' suicide. Effective prevention strategies for this group will require further research into attitudes towards euthanasia.

***Recommendations**:*

17 Collaboration across governments is required to develop a strategy for older Australians to have adequate access to specialty mental health and dementia care services.

18 Primary or Universal Suicide Prevention in Old Age should be part of a Healthy Ageing Health Promotion Strategy. Any strategy that will improve the health of people in old age will be consistent with reducing late life suicide.

19 Secondary or Selective Suicide Prevention strategies should focus on those at high risk (e.g. older people with chronic pain, socially isolated migrants & rural elders, older persons with a history of depression, older persons recently diagnosed with life-threatening illnesses such as cancer or dementia) by training gate keepers about the risk and ways of reducing it.

20 Tertiary or Indicated Suicide prevention should focus on detection of depression and suicide risk in older individuals. More training should be provided for GPs and other health professionals to assist them in identifying potentially high risk individuals and understanding how to better treat depression in those individuals identified.

21 To particularly address the risk of suicide in men in Australia aged over 75 there is a need to:

(i) Research and evaluate attitudes towards euthanasia among older Australians.

(ii) Enhance and impart knowledge about the availability of palliative care and other interventions that reduce perceived burdens on older males and persons closest to them caused by disabling and distressing physical conditions.

(iii) Focus on the special needs of older men who are isolated or disabled and need attention, with a particular focus on older men's psychological health (e.g. by using Men's Sheds).

People who self-harm and suicide attempt survivors, and people transitioning in and out of specialist mental health care

Suicide attempt survivors are an often misunderstood, isolated and neglected group of individuals. It is estimated that more than 170 people attempt suicide every day in Australia [19] however, it is difficult to identify the full prevalence of suicide attempts. Many attempts are not presented for medical attention, and therefore go undetected. In one Australian study it was shown that less than half of those who had attempted suicide sought formal help after their attempt, while only one third received treatment at a hospital [18]. In addition, the majority of those who do come to attention following a suicide attempt do not receive any subsequent help [18]. Non-attendance of suicide attempt survivors at follow-up interviews is alarmingly high with some researchers estimating this non-compliance to be as high as 50 to 60 per cent [19].

Particular attention must also be paid to people who are transitioning between, into or out of mental health care services. This includes those who are moving into primary care and have a reduction of intensity of care, and people recently discharged from a psychiatric unit. The risk for suicide attempts is highest in the month following discharge from a psychiatric unit [31]. This group is a well-defined population where effective suicide prevention strategies could have significant impacts. As part of this strategy there is a need to ensure that all services are open and accessible to those who need it. The Victorian 'No wrong door policy' is a basic principle that ensures that if people go to an agency that may not service their needs directly, they receive guidance to engaging with a service that does. This policy must be implemented Australia-wide.

Engagement, follow-up and maintaining contact with suicide attempt survivors after emergency room contact is critical. Positive results have emerged from recent studies showing that maintaining contact with suicide attempt survivors or those who self-harm after discharge can significantly reduce their risk of subsequent attempts and death. Randomised controlled trials [32-34] have confirmed that brief education and simple continuing support for those who have attempted suicide or other high risk psychiatric patients post-discharge can prevent suicides. Continuing support can be as simple as sending people postcards or letters [32, 33] at least four or five times a year, which has demonstrated effectiveness. More recently an international WHO study [34] has shown that a dual intervention of a one-hour information session, referral options and follow-up contacts (phone or in person) over a period of 18 months is effective. It was also suggested that when contact was reduced or ceased, the preventative effect also disappeared [33].

These successful interventions are relatively inexpensive and work through enhancing social connection and sense of personal value. Allowing for appropriate cultural adaptation, these programs deserve widespread implementation in local settings. This suicide prevention intervention should be costed and

strongly considered for introduction to standard practice in every casualty department and psychiatric ward post-discharge.

***Recommendations**:*

22 Assistance should be provided to people transitioning in and out of specialist mental health services, suicide attempt survivors, and those who self-harm, by offering post-discharge support, particularly for casualty and psychiatric patients. This must include funding and support for interventions that maintain contact and follow-up after the event.

23 The Victorian 'No wrong door policy' of access to services should be introduced Australia-wide.

Indigenous and rural communities

Evidence shows Indigenous Australians aged 12-24 have suicide rates four times greater than non-Indigenous Australians; [13] this disparity is even greater for men in rural and remote communities. Furthermore, non-reliable data may be under-identifying Indigenous status meaning that the figures could be even higher. While overall suicide rates have remained relatively stable over the last century, Indigenous suicide rates are generally increasing [26, 35]. The past 10 years has also seen a higher rate of suicide amongst people, particularly males, in rural and remote areas, with the most significant increases in communities with populations of less than 4,000.

Aboriginal suicide has unique social and political contexts, thus interventions or prevention campaigns should target this high risk group in a culturally appropriate manner. More information about the cultural problems experienced by Indigenous youths in their teenage years is needed to determine appropriate targeted programs and services. Young people in the justice system may need personal support. 6% of young Aboriginal men (aged 25-30 years) in Australia are in prison at any one time, while up to a quarter of all young Aboriginal men will have direct involvement with correctional services each year [36]. These figures are especially worrying given that the first 6-12 months following release from prison is a high risk time for suicide. Recent studies in Western Australia demonstrated that released Aboriginal prisoners have an almost 10 times greater risk of death than the general population, with the main causes being suicide, drug and alcohol related events and motor vehicle accidents [36]. In order to bridge the gap in health inequalities that Aboriginal and Torres Strait Islander people face, it is vital that any suicide policy developed gives this area priority.

All mental health professionals should undertake regular cultural awareness training in order to develop a better understanding of the social and emotional requirements of Aboriginal and Torres Strait Islander people. Further, increasing the availability of tailored services to Indigenous Australians and other groups whose needs are not well met by mainstream services is also warranted if services are to be more effective in future.

There is a pressing need to determine if young people, especially in rural areas, have adequate access to the professional expertise needed to diagnose and treat mental disorders [37]. Social disadvantage influences suicide rates as people with lower levels of education are grossly over represented in suicide rates. Moreover, funding for suicide prevention services has traditionally targeted schools and mental health services. Given that the majority of young men committing suicide were neither in school, nor in a position to or willing to seek medical help, prevention efforts are currently poorly targeted to young rural communities. The lack of appropriate services, particularly in rural communities, may mean that people move to locations where support exists but where they are isolated from their local communities and

support networks. Mental health services need to be community based and available where they are needed in areas of high risk population.

***Recommendations**:*

24 An increase in the number of community services that can provide holistic longer term care for Aboriginal and Torres Strait Islanders that are proficient in recognising mental health issues. The Commonwealth government should invest in mental health generally and suicide identification and prevention specifically for Indigenous populations.

25 Greater incentives should be provided for mental health practitioners to live and practice in rural areas, including access to peer support and continuing professional development opportunities.

Other socially disadvantaged groups (including refugees and asylum seekers)

Suicide rates in immigration detention centres are up to 10 times higher than the general population and serious suicide attempts have been documented in young children and adolescents [38]. Many asylum seekers have suffered persecution and sometimes torture in their countries of origin. They have suffered the stress of separation from family and familiar surroundings. Some have had to survive stressful and dangerous situations as part of their journey. In July 2008 the Australian government announced it was overhauling its controversial refugee immigration policy of mandatory detention for asylum seekers; children are no longer detained in immigration detention centres, while people deemed to pose no danger are able to remain in the community while their visa status is being resolved. Despite improvements in policy and human rights, many asylum seekers continue to be without status and with little access to necessary supports and services, putting them at high-risk of suicide.

All migrants from cultural backgrounds where isolation is accentuated due to an absence of compatriots are at high risk. Australia welcomes large numbers of immigrants each year but the mental health of migrants in these situations can often be overlooked. Asylum seekers and refugee women in particular may have experienced trauma, loss and sexual assault and are a vulnerable group with high rates of psychological distress. Appropriate treatment requires an understanding of an individual's cultural background and experiences, for example, the meaning one gives to violence and trauma can vary depending on culture [39]. Poor working conditions and lack of social supports, can also increase anxiety and depression in these populations.

***Recommendations**:*

26 Culturally appropriate services for asylum seekers and migrants should be provided to ensure mental wellbeing. These services should be available both in cities and in detention centres.

Alcohol and substance users

Research demonstrates that countries which have a drug and alcohol policy have lower suicide rates, when compared to those which only have suicide prevention strategies [40]. This highlights a need to align drug and alcohol services with mental health services.

There is clear evidence of long term harm associated with regular heavy alcohol use. Excessive drinking can both induce and exacerbate mental health problems, including a strong link with suicide. Particular attention must also be paid to the coexistence of alcohol abuse with mental health issues in youth as the majority of substance abuse disorders develop before the age of 18. Drug policies usually

reduce drug supply and provide more rehabilitation treatment [40], which is an essential part of reducing any suicide risk.

***Recommendations**:*

27 Access for clinicians to share their clinical expertise in key community sectors should be increased, such as the alcohol and other drug sector, especially in non-acute settings (in order to reduce hospitalisation rates).

28 Investment in more specialised dual diagnosis (alcohol/drugs and mental health) beds and services across Australia is required.

Families and carers of suicide victims

In addition to grieving the loss of the individual who took his or her own life, survivors – family members, caregivers, and friends - may themselves be at increase risk of suicide. The stigma associated with suicide may lead to reluctance to talk about the problem or to seek out social support and mental health services. It is important to highlight that for many carers, transition out of the caring role only occurs with either the death of the person they are caring for or when the carer becomes incapacitated themselves through illness or mental illness. In terms of those carers that experience the loss of a family member, particularly under traumatic circumstances such as suicide, provisions should be made available for carers to access immediate support services so that they do not end up with a long-term mental illness themselves.

***Recommendations**:*

29 Provisions should be made available for people that experience the loss of a family member under the traumatic circumstances of suicide to access immediate support services.

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

There is much room for improvement of research into suicide and suicide prevention. Government support and collaboration is essential for developing and improving the research program; currently there is a lack of transparency and coordination. Recent studies have sought to inform priority setting in Australian suicide prevention research by seeking stakeholders' views on where future priorities might lie, and undertaking reviews of current literature [41, 42]. These studies highlight that priority should be given to evaluating the efficacy of specific interventions and examining the response of the health and community service systems; this assertion is strongly supported by RANZCP.

Emphasis should be on intervention studies and evaluative activities that focus on groups identified as having particularly high levels of risk of suicide. Identifying effectiveness of suicide prevention programs is essential to inform both policy makers prior to developing strategy, and practitioners and community organisations in how to minimise risk. For example, hotlines may be effective in reaching suicidal adults and in diminishing depression and suicidal intent at the time of calls and in the ensuing weeks, however further research regarding long-term effectiveness is required to inform delivery in the future. There is also a need for further research into self-harm and suicide attempt survivors.

Recommendations*:*

30 Collaboration is required between Federal and State governments in regard to funding research in suicide prevention, including the appointment of a properly constituted expert body to oversee all research into suicide prevention that is linked formally with academic institutions.

31 All suicide prevention strategies should be properly evaluated with at least 15 per cent of all funding allocated to suicide prevention strategies being spent on evaluation.

32 Further research into clinical practices such as increasing staff observations of suicidal patients, hospital admissions, and psychiatric therapies and its effect on suicidal risk should be undertaken.

33 Research into effective suicide prevention strategies for older populations should be undertaken.

34 Research and funding for projects into the lived experiences of suicide attempt survivors should be undertaken.

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

The decrease in suicide rates in Australia, notwithstanding issues of under-reporting as set out in section (b), generally indicates a step in the right direction has been taken in regard to suicide prevention. However, it is difficult to know what to attribute this reduction in rates to. Specifically with regard to the National Suicide Prevention Strategy, it is not possible to determine its effectiveness. The LIFE Framework resources developed under the Australian Government National Suicide Prevention Strategy provides a national platform for the planning and provision of suicide and self-harm prevention activity in Australia. This resource includes a number of laudable aims and objectives in regard to suicide prevention which the RANZCP supports. However, there is currently no evidence to demonstrate that this is the best way to reduce suicide rates. There is a critical need for systematic reflection of the strategy and a commitment to reviewing strategies and publishing their effectiveness.

There is currently little information about lived experience or understanding of internal thoughts or feelings of those who are suicidal. It is crucial that the diversity of voices and narrative experiences of suicide attempt survivors are represented in ongoing policy and program development. Suicide attempt survivors can uniquely contribute to this process by identifying their individual needs and guiding the development of effective prevention and aftercare strategies [19].

Recommendations*:*

35 There should be systems developed to review and monitor the National Suicide Prevention Strategy with a commitment to evaluation and publication of data reflecting the effectiveness of programs.

36 Improved understanding of the lived experience of suicide attempt survivors in all suicide prevention efforts is required, including a stronger focus on incorporating the views and experiences of suicide attempt survivors in the policy, research and development of mental health services and in the development of interventions (and evaluation) for suicide prevention.

4. Conclusion

Mental illness and suicide are closely intertwined and must be addressed concurrently to ensure a holistic approach to improving outcomes. A focus of suicide prevention strategies should be ensuring that the needs of people with mental illness are recognised and met. Suicide prevention should address factors that cause people to become suicidal, including enhancing social inclusion and improving mental health services for both general and high-risk groups. Increased support should be provided for those in the role of gatekeeper, including those who deliver crisis response, in identifying and responding to suicide risk. Accurate reporting of suicide and self-harm figures and comprehension evaluation of the effectiveness of current programs is imperative to the success of future suicide prevention strategies. All future suicide prevention strategies should be developed in a non-stigmatising manner, taking into account the views of those bereaved by suicide and suicide attempt survivors.

The Royal Australian and New Zealand College of Psychiatrists thank the Senate Community Affairs References Committee for the opportunity to make a submission to this important matter and looks forward to working with the Australian Government in the development and implementation of robust suicide prevention strategies in the future. RANZCP would welcome the opportunity to address the Senate Community Affairs References Committee on this matter.

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