Central Coast Submission

for the

NSW Suicide Senate Committee Inquiry

Prepared: November 2009

Submitted By: Suicide Safety Network (Central Coast) Inc.

Suicide Safety Network (Central Coast) Inc.
"Working together for **LIFE!"**

1. Background on Central Coast Suicide Prevention

The Central Coast is acknowledged as being a national leader in Suicide Prevention (prevention, intervention and post-vention) work.

Key Central Coast suicide prevention initiatives include:

- The establishment of the Suicide Safety Network (Central Coast) Inc. (SSN, the Network)
- Grief Counsellors Assisting the Coroners Office
- The establishment of the Lifeline Central Coast (NSW) Sudden Traumatic Death Response Team - which is a partnership program with NSW Police Force and a collaboration between the Central Coast Coroner's Office and key Government and Non-Government Organisations.
- Central Coast Coroner's Office coronial information system database – the Central Coast has played a key role in the national debate about the collection of coronial data around suicide and has a role in the National Coronial Standards in reporting Suicide (NCSRS) Taskforce
- The fencing of the Mooney Mooney bridge on the F3 Freeway
- Men's Phone Forum
- Unique Suicide Research – A collaboration between the SSN (including the Coroner's Office and the Health Promotion Unit (HPU) of the Northern Sydney Central Coast Area Health Service (NSCCAHS) and the Faculty of Primary Health Care at the University of Western Sydney (UWS)

2. Social Context of Suicide

The experience of the Central Coast strongly suggests that the factors involved in suicide are more than just **individual clinically diagnosed mental health issues**. The coronial database shows issues such as unemployment, being single and / or separated are at least as significant statistically as mental health issues / depression as factors in suicide. The 2005 Central Coast Suicide Report shows that mental health / depression make up only about one quarter of the suicide deaths for that year – leaving about three quarters being presumably factors other than mental health / depression [Suicide on the Central Coast 2005 Report - see attachment 2] such as unemployment and relationship statues defined as 'single'. Historically, the emphasis on the individual's 'mental health' has been to the exclusion of adequate research into the social context of suicide.

Compounding this emphasis on mental health / depression (**individual clinically diagnosed mental health issues**) there is a general, pervasive, ambiguity about current terminologies, especially 'depression' / 'mood disorder' and 'mental health'.

'Depression' is used variously to mean anything between 'common blues' to acute clinically diagnosable depression.

'Mental health' is used variously to mean anything between something synonymous with 'mental well-being' to the 'Mental Health Institutional System'.

'Mood disorders' (or affective disorders) refers to a diagnosis of depression or bipolar disorder

Regardless of the clinical diagnosis of an individual, the socio-economic demographics, life stressors and history of the individual are all evidenced factors in suicide. For many clinicians, working within the constraints of a system, these other factors will not weigh as heavily as a clinical diagnosis in the treatment or support to be offered to an individual. Without a clinical diagnosis many individuals are unable to access services or programs that may assist them, or find the waiting lists and costs are prohibitive in accessing services.

A holistic approach, which would include family if appropriate, is required for all individuals seeking the help of services regardless of clinical diagnosis.

This ambiguity creates a significant hindrance to effective suicide prevention strategies.

Recommendations:

1. ***To reduce the ambiguity, we adopt more appropriate terminology to better express the social context of suicide and use 'depression' only for 'clinically diagnosable depression' and 'mental health' only to refer to the 'Mental Health System'.***

2. ***Terms such as 'despair', 'psycho/social crisis' should replace generic 'depression' and terms such as 'personal well-being' should replace the generic 'mental health'.***

3. Transparency, accountability and accessibility of Department of Health and Aging (DoHA) Suicide Prevention and the National Advisory Council on Suicide Prevention.

The Central Coast has had a key role in significant DoHA funded projects, for example the 'SSN / Wesley Mission Replication Project' and the re-writing of the LIFE (Living Is For Everyone) Framework. From this experience our involvement raised concerns regarding the process, transparency and accountability of DoHA Suicide Prevention and the National Advisory Council on Suicide Prevention.

a) Replication Project

Over the period late 2001 until 2005 the Central Coast (the SSN and the Health Promotion Unit – Central Coast) were partners with Wesley Mission and the Federal Department of Health and Ageing (DoHA) in a plan to replicate the Central Coast model of a Suicide Safety Network. The initiation for this came from DoHA itself and not the Central Coast. However, after initially being enthusiastic about this plan, it proved to be a very frustrating experience for the Central Coast.

There were a number of key areas of concern:

- The Central Coast was invited to facilitate the initial planning by providing a template (the Guidelines) for the Central Coast model of a Network. A core element of this was the essential nature of the local coronial data [Suicide Safety Network Replication Guidelines see attachment 1] – any new area would need to have the local coroner's office involved as a key part of the new Network and the Network have access to the local suicide data if it were to be a Central Coast model network.

- These Guidelines were presented to the Steering Committee for the 'Replication

Project' very early on in the project; this point and others appeared to have been largely disregarded as the 'Replication' process got underway.

- Consequently, the final 'Replication Project' did not really represent a replication of the ***Central Coast model*** of a Suicide Safety Network.

- The Central Coast was not invited to be a part of the planning and a number of times were informed of significant changes only after the changes had been made.

- Over a period of about 2 years of the planning stage (including an extended evaluation of the Central Coast Network – there were half a dozen or more changes of DoHA personnel on the steering / management committee; almost a new person for every sitting of the committee. Consequently, the meetings became a series of frustrating attempts to determine the level of knowledge each new DoHA representative and bring them up-to-speed before the proper meeting could begin.

- The second phase rollout of the Network Replication was offered to Wesley directly, and after Members of the SSN being asked to be on the Committee of Management, no actual invitation was forthcoming. Then after some 15 months of the second phase, the Coroner was then approached to be on the Management Committee (when the project become stagnant). SSN Members felt somewhat belittled when told it was too late to be asking comments like *"Lets not dwell on the past, you should be looking to the future"*.

Compounding all of this, DoHA staff was impossible to contact directly.

b) Re-writing of LIFE Framework.

In an acknowledgement of the importance of the Central Coast work, the Central Coast was invited to be a part of the formal consultation process for the re-writing of the LIFE Framework. The process included up-dating and feedback opportunities for participants. We received copies of drafts including the final DRAFT submitted to DoHA. By our continued participation, we implicitly endorsed the process and the final DRAFT.

However, after participation, in good faith, in this process, we were disappointed to know that the final DRAFT was then substantially re-written we can only assume by DoHA and the National Advisory Council – apparently without consultation.

(Terms of Reference c, g. h)

Recommendations:

1. *That DoHA develop a framework for working with other agencies and interest groups that promotes transparency in all dealings, includes guidelines for establishing partnerships and working together collaboratively, and outlines a process of accountability of all parties.*

4. Coronial Records

The contribution to the SSN from the Coroner's Office on the Central Coast is vital to the Central Coast work – this includes the original establishment and on-going maintenance of a coronial database on suicide. The Central Coast Coroner's Office collects the data information and the HPU conducts the statistical analysis and produces an Annual Report.

The local suicide data;

- has been used to influence suicide prevention work (such as the fencing of the Mooney Mooney Bridge)

- has been used as a key part of an important research project– a unique collaboration between the Coroner's Office, the SSN and the University of Western Sydney's Faculty for Primary Health Care – investigating the risk and resilience factors in suicide in men. **Through the Central Coast Coroner's Office the research team was able to make contact with the families and friends of men who had attempted suicided**. This research is now being written up and is expected to make a significant contribution to understanding the social / contextual factors involved in suicide and informing effective suicide prevention strategies.

- has been a key part in raising the profile of the issue around the inadequacy of national suicide data. This debate has led to the formation of the National Coronial Standards In Reporting Suicide (NCSRS) – Central Coast continues to play a role in this national initiative.

(Terms of Reference b, c, g, h)

Recommendations:

1. ***With the established working model between the Central Coast Coroners Office and HPU, funding to be provided to allow the continuation of annual reports, data from the past decade to be published in a paper, and work of this initiative to be supported and evaluated with a view to a National roll out.***

• Current Suicide Prevention Initiatives

- Lifeline Central Coast (NSW) Sudden Traumatic Death Response Team establishment.
- Lifeline Central Coast (NSW) Suicide Bereavement Support Group.
- Consumer / Carer Programs.
- Consumer Theatre Group, Day programs, community support workers, and respite programs all provided by NGO's.
- Carer education sessions provided through the Family and Carers Mental Health program, carer respite.
- NSWPF MATES - Managing Adverse Traumatic Event Stress training developed locally to address officer's mental and emotional wellbeing with a focus on how to reach out and / or provide support to a work mate. This training also supports a Coronial Recommendation made to NSW Police Force after an officer died by

suicide.

- Mental Health First Aid training to workers and carers.
- Development of a Central Coast Suicide Prevention Strategy including the development of resources for health professionals, community workers, carers and consumers to assist individuals; prevention, intervention (acute and non-acute) and post-vention.
- Service Providers Discussion Meetings facilitated by St Vincent de Paul Society and NSW Police Force focusing on local suburbs that have recorded a high prevalence suicide rate according to Central Coast Statistics provided by the Central Coast Coroners Office. The aim is to meet with those service providers on the ground in those suburbs identified, empower them to work collaboratively in developing a coordinated suicide prevention plan.
- Establishment of the 'Iris Foundation' which is a not-for-profit group focused on fund rasing to fund small community suicide prevention initiatives.
- The Central Coast Division of General Practices offers a Suicide Prevention Initiative (pilot) which aims to provide treatment and support to individuals at risk of suicide or self-harm at a critical point in their lives and complements and operates in parallel with the existing ATAPS program. This initiative assists GPs in the management of this specialist group of patients and better integrates care between acute and primary mental health care for the management of this patient.
- Headspace - The headspace initiative aims to change the way mental health services are delivered to young people on the Central Coast, with an emphasis on youth-friendly environments and improved accessibility.

Recommendations:

1. ***Fund a community suicide prevention worker position on the Central Coast.***

2. ***Funding to support a community network of psychologists to fulfil the role of preventative therapists. Currently the Federal Government has provided funding for specially trained psychologists to provide this service under the "Better Outcome of Mental Health (BOMH) scheme.***

Attachment 1:

Suicide Safety Network Replication Guidelines

Essential:

- Local coroner's office database; progress towards the development of a local Coroner's Database based upon the Central Coast model (i.e. support from coroner's office)
- Presentation of recent stats – age (by individual year **not** ABS age brackets), gender, marital status
- Local work to reflect local statistics
- Local Coroner's office suicide data to be available for formal research if required
- Highly motivated community leader(s)
- Support from CEOs – Health, Education, Justice, DOCs, Police Regional Commander
- (formal endorsement / response to request for support from Fed. Minister of Health)
- Support from local Federal Members
- Support from local government
- Support from head personnel at key NGOs
- Establishment of Working Party
- Calling of formal community meeting

Desirable:

- Churches
- Service organisations
- Media support

Attachment 2:

SUICIDE ON THE CENTRAL COAST

2005 REPORT

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INTRODUCTION

In Australia in 2004, 2098 deaths (1.6% of all deaths registered) were attributed to suicide.[1] Suicide death is relatively uncommon however it is preventable and often ends a life very prematurely. The impact on surviving family and friends can be considerable.

The Suicide Safety Network has been working to reduce the toll of Suicide Death on the Central Coast since 1997. The Central Coast Health Promotion Unit is a member of the Network, and produces the yearly suicide report for the Central Coast with the assistance of the Central Coast Coronial Court.

DEFINITION OF SUICIDE

Suicide can be defined as the deliberate taking of one's life. To be classified as a suicide a death must be recognised as due to other than natural causes. It must also be established by coronial enquiry that the death resulted from a deliberate act of the deceased with the intention of ending his or her own life. Possible suicides where the coroner concludes an 'open' finding, and not explicitly suicide, are excluded. [2]

CENTRAL COAST REPORT

This report is based on information collected in the Central Coast Coronial Court. The advantages of collecting data locally include receiving reports in a timely manner, and assisting local groups such as the Suicide Safety Network to reflect on recent outcomes in this area. Another advantage is that the records are those of people who died on the Central Coast, and not just those who reside on the Central Coast. Important interventions such as fencing the Mooney Bridge have had an impact on potential suicide victims from the Central Coast and from other areas. In years prior to 2003, around 3 or 4 people died each year jumping from the Mooney Bridge since its construction. Following a coronial recommendation that the bridge be fenced The Central Coast Suicide Network had sought such action and eventually over a million dollars of state and federal money achieved this. In late 2003, the Mooney Bridge was finally fenced. There have been no deaths to date at this location since it was fenced.

Possible limitations of collecting the data locally include the fact that some cases are now being transferred to Glebe Coroners Court and may be lost to our follow up. Cases where individuals have resided in institutions or been under the care of D.O.C.S. are being transferred. It is estimated that the number of cases lost to follow up will be small, and we will attempt to note them when possible.

CENTRAL COAST DATA

There were 47 suicide deaths on the Central Coast in 2005. Table 1. shows age and gender breakdowns for this period. In 2005, of the four deaths under 25 years there were no teenagers and all were male. Table 2 compares the age of those dying by suicide for the past 11 years.

Table 1 AGE BREAKDOWN OF SUICIDE DEATH ON THE CENTRAL COAST in 2005

	15 to 24 yrs	**25 to 44 yrs**	**45 to 65 yrs**	**65+**	**total**
FEMALE	0	3	4	3	9
MALE	4	16	14	3	38
total	4	19	18	6	47

Table 2 AGE BREAKDOWN OF SUICIDE DEATH ON THE CENTRAL COAST 1995 TO 2005

	1995	**1996**	**1997**	**1998**	**1999**	**2000**	**2001**	**2002**	**2003**	**2004**	**2005**
15-24yrs	2	9	9	5	7	8	7	9	8	6	4
25-44yrs	14	18	26	23	20	19	16	20	12	15	19
45-64yrs	7	10	12	17	7	4	8	9	11	6	18
65+yrs	4	11	5	6	3	7	5	8	6	9	6
Total	27	48	52	51	37	38	36	46	37	36	47

There were just over four male deaths for every female suicide deaths in 2005, which is close to the national ratio (4:1) throughout the period 1994-2004. [1] Table 3 shows the gender breakdown from 1995 to 2005.

Table 3 GENDER BREAKDOWN OF SUICIDE DEATH ON THE CENTRAL COAST 1995 TO 2005

	1995	**1996**	**1997**	**1998**	**1999**	**2000**	**2001**	**2002**	**2003**	**2004**	**2005**
Male	20	42	40	43	28	31	32	28	25	30	38
Female	7	6	12	8	9	7	4	18	12	6	9

ASSOCIATED FACTORS

It is difficult, from posthumous analysis of Coronial records, to accurately gauge the weight of associated factors in terms of contribution to a person's final decision to takes their own life. However we can gain an impression from posthumous data collected from friends and family.

Fourteen of the 47 (3/9 females and 11/38 males) suicides on the Central Coast in 2005, had previously attempted suicide. Eleven of these (1/9 females, 10/38 males) had been seen by Central Coast Mental Health services in the previous 12 months, and twelve (1/9 females, 11/38 males) were thought to have received treatment for depression within the previous 12 months.

Eleven people suffered a suicide death in the context of a relationship problem; eight of these were male and three female. Three males and one female had family law issues. Few financial problems were associated in either gender (3/38 male and 1/9 female) which may be a reflection on relatively good economic climate with low interest rates and low unemployment in this period. Only one individual was noted to have gambling problems.

Eight individuals had a serious physical problem, and they were mostly 50 years or older.

Ten individuals had a pending criminal issue.

Post-mortem examination results for substances showed that 6 males and 3 females had BAC (alcohol) over 0.05 and a further 5 males had BAC that were positive but less than 0.05. Two males had THC (cannabis) detected in their urine indicating use within days or weeks of death.

Eight males and 3 females had a history of unresolved alcohol abuse. Four individuals had a history of cannabis abuse, two with narcotic abuse and 4 with amphetamine abuse. In all 16 individuals had a history of abuse of alcohol and/or other substances that was unresolved at the time of death, of the total 47 suicide deaths.

MODE OF DEATH

In 2004 the most common means of suicide was hanging. In 2005 three different methods were prominent: Hanging, Carbon monoxide gassing, and overdose of prescribed and illicit substances.

Table 4 MODE OF DEATH

	Male	Female
Hanging	11	3
Gas	10	2
OD Prescribed	6	4
OD Illicit	5	0

Table 5 and Table 6 present the breakdown of marital status and employment.

Table 5 EMPLOYMENT STATUS

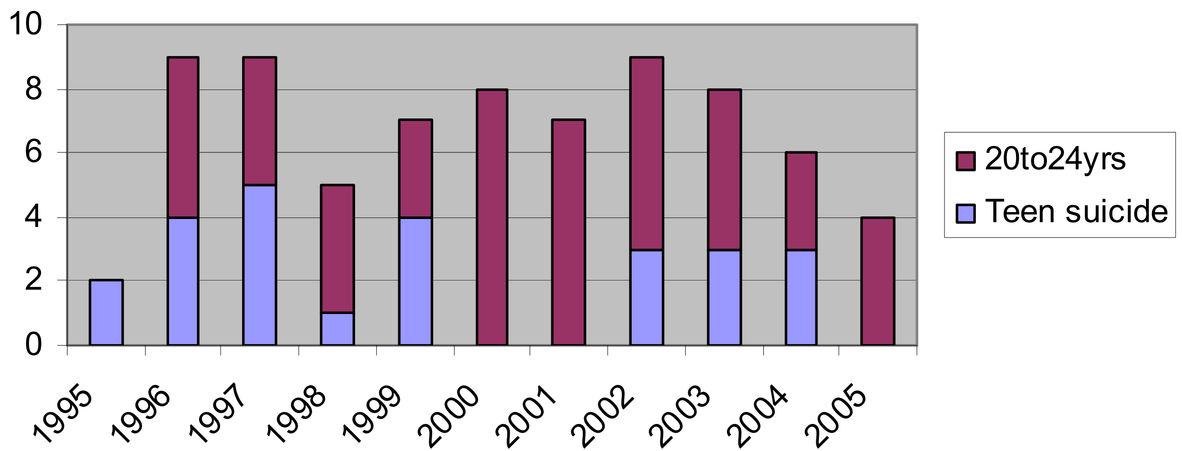
	female	**male**	**total**
Disability pension	1	2	3
professional	1	2	3
retired	2	5	7
skilled/trade	1	6	7
unemployed	1	16	17
unskilled	1	5	6
Home duties	2	0	2
Untitled	0	2	2
(total)	9	38	47

Table 6 MARITAL STATUS

	female	**male**	total
defacto	0	3	3
divorced	1	2	3
married	3	5	8
separated	1	5	6
single	4	19	23
widowed	0	3	3
Untitled	0	1	1
(total)	9	38	47

Chart 1 displays the breakdown of youth suicide into teen suicide and suicide in 20 to 24 year olds. Teen suicide attracts substantial attention. In the past decade we had an average of 2.5 teen suicide deaths per year on the Central Coast, while the majority of 'youth' suicide deaths were in 20 to 24yr olds averaging 4.5 suicide deaths per year. In 2005 there were no suicides amongst teenagers on the Central Coast.

Chart 1



Prepared in Consultation with Key Government and Non-Government Organisations, November, 2009.

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[1] www.abs.gov.au 3309.0.55.001 Suicide: Recent Trends, Australia. Main Features 15/12/2004

[2] www.abs.gov.au 3309.0.55.001 Suicide: Recent Trends, Australia. Explanatory Notes 2/12/2003