Let's Get Serious: The Infrastructure to Effectively Address Suicide in Australia

A Submission to the Senate Community Affairs Committee Inquiry on Suicide in Australia

Prepared for

The Suicide Prevention Taskforce & Suicide Prevention Australia Inc.

20 November 2009

Background

In 2008, Suicide Prevention Australia Inc. (SPA) undertook a comprehensive organisational review and evaluation of its performance against the 2005-8 Strategic Plan. The review included extensive consultations and evaluation processes with a wide range of stakeholders.

A key theme from those consultations were issues concerning the policy framework, governance and structures to support and drive a national suicide prevention agenda. Consequently, these issues became central to the new SPA strategic plan which articulates the need to advocate for and lead the development of new national structures to more effectively address suicide awareness, suicide prevention, intervention and postvention service provision in Australia. (Refer to http://www.suicidepreventionaust.org.au)

A 'Taskforce' of individuals and organisations committed to this objective was formed in established in May 2008 to drive this agenda and has developed this Submission for the Senate Inquiry into Suicide in Australia. Membership of the Taskforce is listed at the end of this Submission.

Context

Government Leadership

Australia has a relatively long history of national public policy in the prevention of suicide. The initial suicide prevention strategy, the National Youth Suicide Prevention Strategy was commenced by the Keating Government in 1995. In 1999, the National Suicide Prevention Strategy (NSPS) was established by the Australian Government. In 2000, the Howard Government released the *LIFE Framework [Living is for Everyone]*) and by 2006, most States and Territories in Australia had adopted their own suicide prevention strategies largely based on the LIFE Framework. Local government involvement has been largely limited to measures to curb suicides and suicide attempts at particular public places rather than a planned strategic approach.

Under the Keating and Howard Governments investment in national suicide prevention remained at approximately $10m per annum for a decade while some states and territories made smaller investments, most notably WA.

During 2005-6 the Australian landscape in mental health dramatically altered. This followed the release of the report *Not For Service: Experiences of injustice and despair in mental health care in Australia* in October 2005 from the Mental Health Council of Australia (MHCA) and the Senate Inquiry and report *From Crisis to Community* in March 2006. Both of these reports emanated from widespread public and political concern that reform of mental health was demonstrably failing the Australian community. In response to these reports, the Council of Australian Governments (CoAG) agreed in July 2006 to inject an additional $4b into mental health services over the next five years; subsequently increased to over $5b.

Under the COAG National Action Plan on Mental Health, the Commonwealth increased its contribution to suicide prevention by an additional $62.4m over five years bringing the annual suicide prevention specific federal budget to around $20m per annum.

The LIFE Framework has served since its development in 2000-1 as a proxy for a National Suicide Prevention Strategy. The NSPS is not a national policy or strategy endorsed by all governments through COAG. It has never been endorsed by the Australian Health Ministers'

Conference or other inter-government forum. Nor is it a whole-of-Commonwealth Government policy or strategy as it does not have the engagement in development or deployment of a whole-of-government strategy. It is a strategy developed by and deployed by the Commonwealth Department of Health and Ageing (DOHA).

DOHA has had responsibility, and remains responsible, for the NSPS and LIFE Framework. In 2000, the then Minister for Health, the Hon Michael Wooldridge, established the National Advisory Committee on Suicide Prevention (NACSP). The NACSP was specifically established to provide the Prime Minister and Minister with strategic advice on suicide and suicide prevention. The NACSP also had within it an 'Executive Board' of three. The Department also established the Suicide Prevention Advisory Committee (SPAC) for advising on funding of community based projects in the initial stages of the NSPS, a Community and Expert Advisory Forum and an Evaluation Working Group (EWG), a State and Territory Forum and a Commonwealth Interagency Forum. Some of these bodies never met.

In 2004, these structures were revised with five structures remaining – 'the Board' (15 cabinet appointed experts); The 'Community and Expert Advisory Forum' (a 20 person forum to provide advice to 'the Board'); 'State and Territory Suicide Prevention Advisory Committees' (SPACs); the 'Evaluation Working Group' (EWG); and the 'Annual Suicide Prevention Planning Forum'. The records indicate that some of these groups met only once or twice over the period 2004-2008. Secretariat support was vested in DOHA and in some state/territory health departments.

Philosophy and National Strategy

The prevention of suicide in Australia, as articulated in policy document, has been seen as a shared responsibility across all sectors, organisations and communities. Investing in the capacity of communities so that they are empowered to have a role in shaping their own future is recognised universally as a key strategy to achieving safe, healthy and resilient communities and this has been the cornerstone for both the national and state/territory approaches to suicide prevention.

During the first phase of the NSPS (1999-2006) over 150 community projects have been funded across the states and territories and some 27 national projects were also funded. Most of the community projects were one off grants for small-scale projects.

The stated aims of the NSPS at this time were:

- To support national suicide prevention activities across the life span; and
- To develop and implement a strategic framework for a whole of government and whole of community approach to suicide prevention across all levels of government, the community and business.

The strategic framework guiding the NSPS has been (and remains) the Life Framework.

The NSPS approach to funding small scale projects has been likened to 'spreading confetti across the land'.

While this approach of investing through small grants has developed some capacity in communities to respond to suicide, few projects have been sustained, and even fewer evaluated (Urbis, Young Keys, 2006). Some 40% of the community projects identified young people (up to age 25) as the primary target group whilst 29% of the projects identified

Indigenous people as the primary target group. Most of the national projects utilised population based approaches that aimed to address risk or protective factors for suicide. Some of these projects were funded jointly from the National Mental Health Strategy, although transparency of these investments is poor.

Most communities and organisations respond to a suicide or a cluster of suicides and have had little support or guidance from government in how to do this. For example, following a cluster of nine youth suicides in the Mackay region in Queensland in 2007-8, the State Government invested some $250,000 in a local youth generic service and provided some limited outreach service from an already significantly under-resourced community mental health team (i.e. in May 2009 this team was staffed at 42% of the Qld Health planned target). However the NGOs and other stakeholders report that they were left to 'figure out what to do without additional resources'. Likewise across the insurance and superannuation industries, reforms to policies and practices related to the underwriting and claims management of cases involving suicide and efforts to prevent suicide among fund members, have proceeded without any guidance, support or funding from government. In terms of local government involvement, suicide prevention efforts are largely ad hoc and reactive to a suicide cluster and focussed on physical barriers at known suicide sites. However, there is no evidence of a coordinated national response through the Local Government association or other peak bodies.

In 2005, DOHA engaged an external consultant (Urbis Keys Young) to undertake an evaluation of the Life Framework. This was completed in April 2006. Regrettably, the report was not released until April 2009, well after the subsequent review of the Life Framework was complete. The evaluation report's key points included:

- That most gains in the NSPS investments to the end of 2005 occurred in relation to capacity building at the individual and service level including increased networks, and increased access to support and resources;
- The governance arrangements for the NSPS are complex and need review;
- Funding decisions need to be based on needs – suicide rates and local issues – rather than be demand or application driven;
- There was little evidence to show that projects under the NSPS reduced suicide or self-harming behaviours; and
- The NSPS would benefit from more specific goals and objectives (including clearer linkage with other larger programs such as mental health strategy), a more effective evaluation framework, a comprehensive research agenda, streamlined governance, and strengthening the program information systems.

Following the evaluation, DOHA commenced a major revision of the LIFE Framework in late 2006 which was completed by the consultants in July 2007 following extensive national stakeholder consultations. One of three elements of the revised Life Framework documents was released by the Hon. Senator Brett Mason on XXX October 2007. This document was placed on the Department of Health and Ageing website, but not published in print form. The document differed significantly from that completed by the consultants and was never subject to stakeholder review or comment. The revised LIFE Framework and the related documents under the LIFE Framework, namely *Research and Evidence in Suicide Prevention* and *Practical Resources for Suicide Prevention* were released in July 2008.

In mid-2008 the Federal Health Minister, the Hon. Nicola Roxon, announced the establishment of the Australian Suicide Prevention Advisory Council (ASPAC) and a new work plan for the NSPS with an emphasis on:

- Selective interventions for high risk groups
- Service provision through better coordination and streamlined referral pathways known as “safety nets”
- Collaboration and joint planning with the states and territories and community organisations and
- Strengthening the evidence base including an additional funding of $1.5m over three years for the Australian Institute for Suicide Research and Prevention (AISRAP).

Suicide and Self Harm Prevalence

While suicide rates, as reported by the Australian Bureau of Statistics (ABS), have shown an apparent decline over the ten years from 1998-2007, the rates remain at historically high levels. Suicide is now the leading cause of death for adult men under the age of 44 years and adult women under the age of 34 years.

It is widely accepted in the literature that the suicide rates are significantly under reported (by a factor 30-40%) and some evidence that the rate of under-reporting is increasing (De Leo, 2007, Harrison, 2008, De Leo et al 2009). The ABS has now commenced remedial action to address the shortcomings in data.

Once this remedial action is complete, there will remain significant under-reporting of suicide in Australia due to a number of factors. One factor is the contribution made by single vehicle accidents to the road fatality data. In recent years, single vehicle road fatalities have increased significantly. Single vehicle road deaths now total nearly 50% of all road fatalities and appear to be unresponsive to road trauma reduction strategies which suggest other factors are responsible. While there is little doubt a range of factors contributes to this increase, anecdotal evidence from Police, Emergency Services and insurers indicates a growing view that a number of these fatalities are suicides.

International comparisons are also relevant with Australia doing no better than other developed nations where there has been no national suicide prevention strategy or ‘framework’. Reductions in the past decade in Australian suicide rates mirror reductions in other developed nations and the paucity of evaluation on interventions makes drawing any conclusions about the efficacy of the NSPS highly contestable.

Mood disorders, including depression and anxiety, alcohol-related disorders and schizophrenia are most frequently associated with suicide. Rates of death by suicide of 10 per cent for schizophrenia and 15 per cent for bipolar are often quoted. People with a mental illness are also more than ten times more likely to have had serious suicidal thoughts than other individuals. Access to effective mental health care is therefore fundamental to national efforts to reduce suicide and self-harm.

The most recent ABS Survey on mental health (2007) also shows little if any progress on increasing access to mental health services – only around 35% of people with a need for mental health care received any care and 65% of people with a need for mental health care go untreated. A number of reports (NSW Sentinel Events, Victorian Auditor General, and

numerous coronial reports) highlight the failure to access quality mental health care and the lack of post-acute care and follow-up in the community as contributing to a significant number of suicides in Australia.

Unless all Australian governments do better in terms of providing accessible and effective mental health care, then other efforts on suicide and self-harm reduction will remain largely ineffective. It is clear that for real reduction in suicide rates to occur, significant new investment of funding and community engagement needs to occur.

New Structure for Suicide Prevention

The Taskforce is proposing that a new governance and accountability structure for suicide prevention in Australia is now necessary. The key reasons for this are:

- Engaging a wide coalition of stakeholders across the Australian community – not just a whole-of-government approach but a whole-of-community approach is now possible given where suicide prevention now sits in public policy and community terms.
- There is a need to broaden the funding base from non-government sources - that is, from community, philanthropic, unions and other collectives and business sources – to supplement the contributions made by governments. Funding must be significantly increased to have an impact on suicide rates and address the social and economic costs of suicide and self harm.
- There is a need and opportunity to provide greater ownership, engagement, transparency and accountability for and to the Australian community as well as assisting the community to understand clearly where they need to go to get the services they need or to financially support this crucial social issue.

Currently there are major reforms of the health system being canvassed in the Australian community. The Rudd Government is placing increased emphasis on the need to re-balance our health system with a greater focus on prevention and early intervention. New financing mechanisms, new structures and governance arrangements are being canvassed.

In relation to suicide prevention, the Suicide Prevention Taskforce believes new structures need to be developed or re-positioned for:

- Raising and distributing funding – from across the community from a wide variety of sources;
- Structures for governance and accountability need to be established – potentially independent of government and service agencies;
- Service delivery, capacity building, community awareness and education, and advocacy need to be appropriately resourced and not reliant on ad hoc funding arrangements.

The Taskforce has examined a range of models from both Australia and overseas on suicide prevention, HIV prevention, road safety and breast cancer and believes that such models offer sound bases for the suicide prevention agenda.

Rationale for a New Approach

Suicide is, and remains, a major cause of preventable loss of life in Australia. Historically, suicide rates climb during periods of economic downturn. The capacity of governments to fund new policies and programs in the decade ahead, as a consequence of the global economic recession, is generally seen as limited. There is therefore no better time to do a lot better with the available resources and to make a greater effort to secure new resources and new collaborators.

A new national structure to implement a coordinated, multi-strategy approach to suicide and prevention is required. The rationale for this new approach is:

1. Suicide and suicidal behaviours, including self harm, remain unacceptably high in the Australian community with the number of suicide deaths significantly higher than the combined national road fatality and homicide rates. The damage to individuals, families and communities is immeasurable. Suicide remains largely, "a hidden epidemic" in public health terms.
2. Suicide, the prevention of suicide and support for the bereaved and attempt survivors, are becoming increasingly important to the Australian community. Media coverage of a number of high profile cases involving prominent and 'successful' Australians have highlighted the complexities, the need to find answers and the need for an assertive response.
3. The bureaucracy, specifically health, has been largely responsible for the efforts to date on suicide prevention and related issues. Ongoing changes in personnel, machinery of government and policy frameworks have impeded progress and outcomes. Historically, health bureaucracies have a poor track record in leading change in health outcomes (e.g. changes in health outcomes such as alcohol, tobacco, HIV / AIDS, road trauma, have all come from the community and community sector). Health Departments have limitations in being able to provide the leadership for a whole-of-government issue like suicide prevention and bring about the structural and broader societal changes necessary to tackle complex issues like suicide and they are limited in their ability to implement whole-of-community programs.
4. Suicide is not (only) a health issue. It is a complex social problem with many risk factors and triggers – some which are understood and many which are not. There are a number of sectors – private, public and community – with a stake in suicide and suicide prevention. These include large corporations with employee populations with higher than average rates of suicide; public sector agencies with an interest in sustaining rural and regional Australia, superannuation and insurance industries, transport, community and education; Indigenous communities and community organisations providing housing and employment programs and so on. Presently these organisations are doing what they can or wondering what they can do – they are looking for leadership.

Principles for Suicide Prevention

The following principles should underpin suicide prevention efforts.

- Suicide and suicidal behaviour arise from complex social, emotional, spiritual, situational, illness and other individual causes, which isolate people and erode their

hope. Understanding risk and protective factors for different groups and environments is vital to developing an effective response.

- Suicide prevention is ‘everyone’s business’, whether it is directed towards individuals at high risk, communities and groups at potential risk, or the whole of the population.
- The first person voices of suicidal, self-harming and suicide-bereaved people are crucial to increasing our understanding of suicide and effective suicide prevention responses.
- Building in every person and every community, a sense of belonging, of meaning and hope in life, is fundamental to suicide prevention. Tackling social exclusion through investing in the human capital of all people, especially the most disadvantaged, is the building block for effective suicide prevention efforts.
- Suicide prevention encompasses a range of interventions, including health promotion and prevention, crisis support and ongoing intervention for people experiencing suicidal thoughts, behaviour and self-harm, and responding to and supporting families and communities bereaved by suicide.
- Access should be provided to appropriate services for individuals at-risk, wherever and whoever they are – through crisis, ongoing intervention and recovery phases. Collaboration, coordination and continuity of care are essential to the effectiveness of services. Program, structural and policy barriers that inhibit help-seeking and the quality of support need to be identified and overcome.
- Suicide prevention strategies should be culturally appropriate.
- The ongoing systemic evaluation of suicide prevention projects, activities and strategies is integral to continued development of best practice in the area of suicide and self-harm prevention.
- Challenging misconceptions about suicide and the stigma associated with self-harm and suicide is essential for the development of broad educational and advocacy campaigns about suicide. It is also critical to the recognition, protection and fulfilment of the rights of those affected by suicide and self-harm

Possibilities for National Suicide Prevention Structure

A new national structure for suicide prevention could provide an opportunity to increase social impact, clarify roles and functions of various service providers and significantly increase the resources available for suicide prevention and related activities.

A clear learning from other sectors such as HIV and breast cancer is that clarity of roles and responsibilities ensures that scarce resources are well utilised and effectiveness is increased. A key benefit in Australia at present is that the suicide prevention sector is still in its infancy which provides an opportunity to establish a clear structure to support effective advocacy, fundraising, service delivery and research that will support best practice. In addition key people in this sector are highly engaged and committed to working collaboratively to minimise duplication of effort and confusion for consumers.

The organisation would be established in such a way as to enable significant contributions from the state/territory governments, the business and community sectors and the Australian public.

The new National Preventative Health Agency with a mandate to address mental health promotion and suicide prevention is one possibility among many. Likewise, new governance

options canvassed in the National Health and Hospital Reform Commission interim report which have application and implications for suicide prevention. Other options include a Federal Statutory Authority (as has been done in anti-doping, blood services and many others), a Federal executive office, akin to the Australian Transport Safety Bureau or a formalised coalition of key agencies.

The Taskforce is mindful of the need to consider a range of structural options in discussing the forms that one or more new organisations might take in this area. What is clear at this point is that there are a range of functions necessary to pursue a more effective, integrated national strategy and build on the achievements to date.

Some of the key elements of the proposed new structure could be:

1) A New Coordinating Body

Reducing suicide and self harm across the community through effective national leadership.

This body would:

- Provide overall governance, monitoring and accountability for the three entities which would sit underneath. Its key role and function would be to monitor the performance of the 3 subsidiary entities to ensure alignment with strategic priorities,
- Approve strategic priorities for suicide prevention in Australia based on current evidence, emerging trends and advice and allocate funding to achieve strategic priorities.
- Largely comprise a board and secretariat.

2) A Peak Advocacy Body (consumer focus)

This enterprise would:

- Advocate on behalf of service providers and those affected by suicide on any initiatives that would reduce suicide and its impact and increase hopefulness in Australian society. Some of these activities in particular could be to:
  - Provide strategic advice to the governing body, government, other stakeholders and service providers on strategic priorities.
  - Maintain a membership base of service providers.
  - Support networking and evidence-based best practice for service providers.
  - Support coordinated capacity building, community awareness & education in communities to minimise suicide and self-harm and minimise duplication of service delivery.
  - Support workforce development through evidence-based practice and knowledge transfer and uptake in the workforce and across the broader community.
  - Provide regional and international leadership on suicide prevention (particularly in the Asia-Pacific). Establish and support partnerships with key industry groups, peak bodies and other key stakeholders.
  - Assess, monitor and report on the impact of public policies or social developments which may (or do) impact on suicide rates (i.e. through such mechanisms as Social Impact Assessments).

- Address structural issues that impact on suicide including urban design, housing, insurance and superannuation.
- Ensuring that the voice of attempt survivors and bereaved survivors is central to decision-making

3) A Suicide Prevention Council and Resource Centre

This body would:

- Develop, collect and disseminate information for service providers through an on-line library of resources.
- Develop, coordinate and disseminate the NSPS communication strategy.
- Develop national policy on suicide prevention.
- Develop a national research strategy which includes provision of research funding, mechanisms to leverage research investment and evaluate and disseminate the findings of research.
- Establish national standards and accreditation systems for people and organisations working in suicide prevention and establish a registry of best practice across a spectrum of care.
- Based on current research and emerging trends in suicide prevention develop practice guidelines for service providers, researchers and other key stakeholders.

4) A Foundation

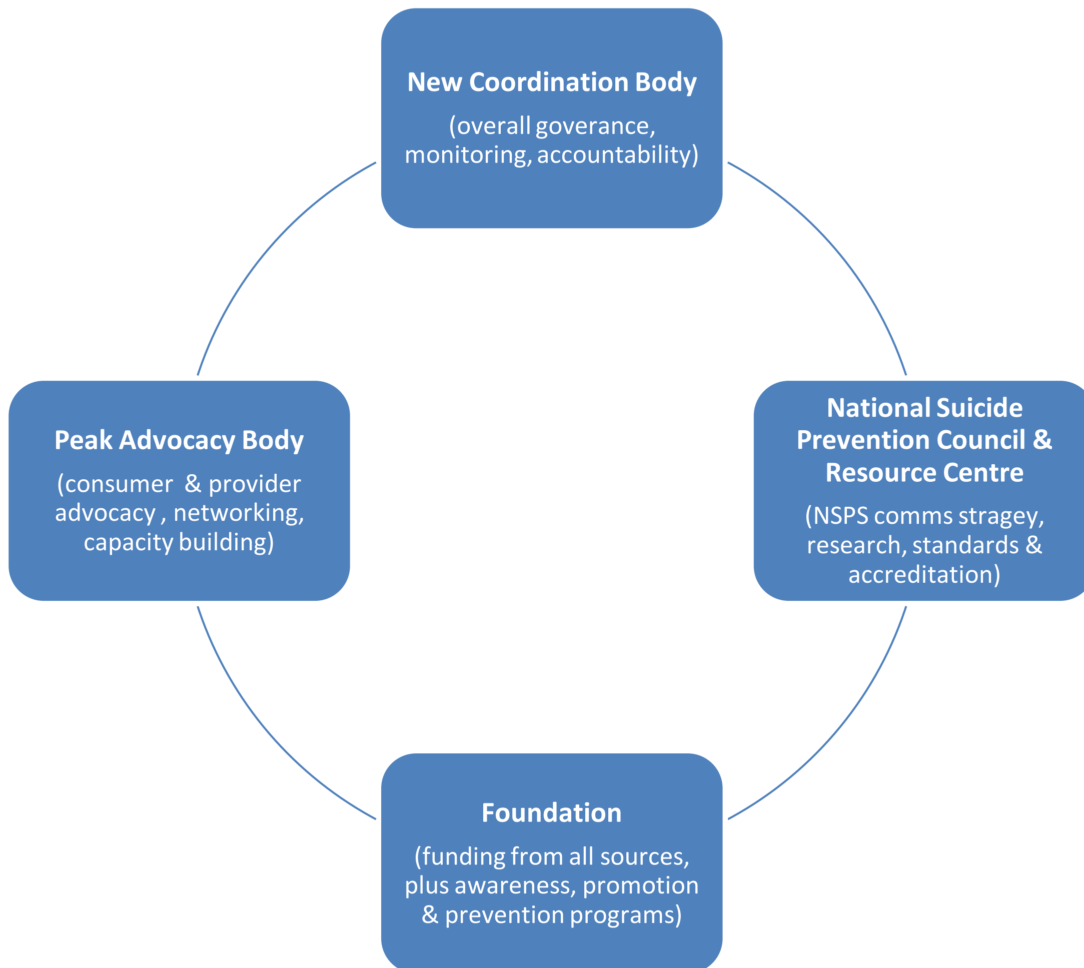
A new national foundation in suicide prevention could provide an opportunity to significantly increase the resources available for suicide prevention and self harm prevention and related activities. Funding from government, business, community and philanthropic sources could be raised by a Foundation. The Foundation would also need to conduct awareness, promotion and prevention programs to increase the visibility of both the issue and the need for funds. Similar models have been highly effective in breast cancer and HIV /AIDS in Australia in the past two decades.

The Foundation would need to have a board of trustees who are highly credible individuals with strong connections in media, business and government to enable effective fundraising and awareness-raising.

This body would also primarily be responsible for the public media strategy and stigma reduction or help seeking programs.

Funds would be raised for strategic priorities such as research advocacy and service provision. Strategic priorities would be recommended by each of the three entities with the governing body making the final determination.

The following diagram illustrates a possible structure and is presented here purely for illustration.



The Suicide Prevention Taskforce Membership

The Taskforce membership is:

Dr Michael Dudley – Suicide Prevention Australia (SPA)
Dawn O'Neil AM – Lifeline Australia
Wayne Koivo AM – Former Member of NACSP
Kerry Graham – Inspire Foundation
Jill Chapman – Mosh (and SPA Board Member)
Adj Professor John Mendoza – ConNetica Consulting Pty Ltd
Louise Duff – Brilliant Logic Pty Ltd
Ryan McGlaughlin – SPA secretariat