Committee Secretary
Senate Community Affairs References Committee
PO Box 6100
Parliament House
Canberra ACT 2600

RE: Inquiry into Suicide in Australia

The WA Ministerial Council for Suicide Prevention is an advisory body to the WA Minister for Mental Health. The Council has recently been reconvened with an entirely new membership and a mandate to oversee the implementation of the WA State Suicide Prevention Strategy, a four year, $15 million commitment which, we understand, is the most significant commitment of a State Government directly to suicide prevention in Australia to date. A copy of the WA State Suicide Prevention Strategy 2009-2013 is attached for your consideration.

The Strategy aligns with the National Suicide Prevention Strategy, including the same Key Action Areas. A hallmark of the WA State Strategy will be a strong Community Development approach. This has been adopted following extensive consultation in 2007. The procurement process to appoint a non-government agency to manage the implementation of the Strategy is currently underway, with an appointment anticipated by the end of 2009.

In the interim the WA Ministerial Council for Suicide Prevention would like to take this opportunity to make a few preliminary points to the Senate Inquiry. These points relate to issues of baseline data and cooperation between National and State Suicide Prevention Strategies.

There appear to be some significant gaps in available data collections that are needed to effectively plan interventions at the State level. These include consistent and comparable data on completed suicides across jurisdictions in Australia. Although WA has developed a process for collecting data from closed Coronial files, there is a need to develop standardized data collection systems based on clear definitions within a consistent policy framework. The work of Suicide Prevention Australia in this area could be built on to progress this issue.

The availability of accurate data on deliberate self harm also appears to be lacking. As a major high-risk group, people who present with deliberate self harm to Hospital Emergency Departments as well as to community based services are of particular interest. There does not appear to be a consistent national approach to how data is collected with regard to presentations of deliberate self harm. This makes it difficult to plan for services that link critical treatment services with ongoing care in the community.

The WA Ministerial Council for Suicide Prevention looks forward to working closely with the Commonwealth through the National Suicide Prevention Program and the Australian Suicide Prevention Advisory Council towards achieving the outcomes of the LiFE Framework. The Council would welcome the opportunity to engage more fully with the Inquiry process, once the infrastructure is in place and the Council has had a chance to consider its position on a wide range of matters. In the meantime we commend the WA State Suicide Prevention Strategy 2009-2013 to you and are happy to answer any subsequent questions the Committee may have about the Council or the implementation process.

Sincerely

John Franklyn
Chairman, WA Ministerial Council for Suicide Prevention
18th November 2009

Western Australian
Suicide Prevention Strategy
2009 – 2013

Everybody's business

Delivering a **Healthy WA**

The term Aboriginal is used throughout the Strategy and refers to both Aboriginal and Torres Strait Islander people as Indigenous Australians. The Capital 'A' in Australian Aboriginal distinguishes them from other aboriginal peoples.[1] The authors acknowledge the considerable cultural diversity throughout Western Australia and the term Aboriginal is not intended to imply cultural homogeneity.

Acknowledgements:

Contents

Foreword

Preventing suicide and suicidal behaviour is a key priority for the Government of Western Australia.

Suicide is a tragedy that results in the loss of loved and valuable lives. The effects of suicide have a profound impact on the lives of those people who are left behind. In Australia over the last 20 years, more people have died from suicide every year than people who have died on our roads. Suicide is a complex phenomenon; there is no single cause for suicide and there is no single solution. However, in many cases, suicide is preventable. It is the duty of all levels of government and the community to work together to reduce the rate of suicide in Western Australia.

Significant areas of improvement in suicide prevention have been made in recent years, such as the reduction in the overall rates of youth suicide and deaths in custody. However, it is clear that other areas of our community continue to experience challenges with suicide and suicidal behaviour. For instance, the alarmingly high occurrence of suicide among young Aboriginal Western Australians is cause for great concern.

In recent years, there has been a call for the State Government to spearhead a comprehensive suicide prevention strategy and to coordinate the collective efforts of many agencies involved in suicide prevention across government and community.

The Western Australian Suicide Prevention Strategy (Strategy) outlines a significant State Government and community commitment to suicide and self-harm prevention. The Strategy has been developed from an analysis of almost 20 years of data on suicide and self-harm in Western Australia, a comprehensive literature review of suicide prevention research and an extensive statewide consultation process. This Strategy is aligned with the National Suicide Prevention Strategy: *Living is for Everyone* (LIFE) and provides a framework and governance structure to guide initiatives in Western Australia for the future.

We commend the release of the Strategy and urge everyone to work collaboratively in supporting the directions taken to improve the mental health and wellbeing of all Western Australians.

The Honourable Dr Graham Jacobs MLA
Minister for Mental Health

The Honourable Helen Morton MLC
Parliamentary Secretary to the
Minister for Mental Health

As part of our aim to improve the mental health and wellbeing of all Western Australians, the State Government is launching the Strategy to address the unacceptably high suicide rate in Western Australia. Each year in Western Australia, over 200 people commit suicide and an even greater number harm themselves in suicide attempts.

To reduce the number of suicides in Western Australia, the State Government has committed $13 million over the next four years to implement the Strategy.

The Minister for Mental Health is responsible for leading the Strategy and has been mandated by Cabinet to ensure that all State Government departments prioritise suicide prevention and participate in a coordinated response to the issue. The support of all levels of government and the private and not-for-profit sectors is essential to achieve positive outcomes in the area of suicide prevention.

The Minister for Mental Health will give new direction and responsibility to a revised Ministerial Council for Suicide Prevention whose membership will be drawn from suicide prevention experts; community, corporate and government organisations; and people who have been impacted by suicide. The Ministerial Council for Suicide Prevention will coordinate statewide initiatives for suicide prevention, identify communities requiring additional support and make recommendations to the Minister for Mental Health on matters related to suicide.

Using existing recurrent resources, a non-government organisation will be appointed and will assume responsibility for the day to day work of the Ministerial Council for Suicide Prevention; the development and delivery of community awareness initiatives; and the coordination of training, research and evaluation of suicide prevention strategies across Western Australia.

The non-government organisation will actively attract support across sectors and work with individual communities and agencies across Western Australia. The non-government organisation will be responsible for facilitating a coordinated agency and local response to communities experiencing early signs of a suicide crisis. Where a crisis occurs in an Aboriginal community, culturally secure community and agency responses will be supported by specialist Aboriginal services.

The non-government organisation will employ a Network Coordinator to engage communities and outline how they can implement the Strategy. In addition, an Agency Coordinator will engage government, non-government and corporate agencies to establish organisation-wide suicide prevention strategies. The Agency Coordinator will also gain a commitment from each agency for participation in future suicide prevention initiatives at a community level.

Locally employed Community Coordinators, who also report to the non-government organisation, will support Western Australian communities by working with community members and agencies in mapping existing suicide prevention activities and determining the need for future initiatives. This work will inform the development of Community Action Plans which will outline the additional supports required; how these can be resourced; and how individuals, groups and organisations can work more collaboratively to reduce the number of suicides.

Summary: What the Strategy will do and how it will be implemented

The Western Australian Suicide Prevention Strategy ('the Strategy') outlines a significant State Government and community commitment to suicide and self-harm prevention.

The State Government has committed to spending $13 million in the next four years to implement a comprehensive strategy with a particular emphasis on young people, young men, Aboriginal people and people who live in rural and regional Western Australia.

The Strategy is aligned with the National Suicide Prevention Strategy: *Living is for Everyone* (LIFE) and provides a framework and governance structure to guide initiatives in Western Australia for the future.

The LIFE framework contains six action areas that will guide future suicide prevention activities and thereby contribute to a reduction in suicide and suicide attempts.

Action Area 1	Action Area 2
Improving the evidence base and understanding of suicide prevention	**Building individual resilience and the capacity for self-help**
Action Area 1 will be achieved through:	Action Area 2 will be achieved through:
- undertaking targeted research and evaluation on suicide and suicide prevention; - developing the evidence base to better understanding the warning signs, tipping points and risk factors for suicide; - improving the evidence base regarding community capacity and resilience-building for the prevention of suicide; and - improving the understanding of the most effective interventions for Aboriginal communities.	- adopting and promoting universal programs to support the acquisition of life skills that enhance individual and community resilience; - adopting and promoting mental health and wellbeing programs for the whole community as well as high-risk groups; - fostering environments (e.g. families, schools, workplaces) where the expression of emotions such as anxiety, stress, sadness and grief is met without fear or stigmatisation; - adopting and promoting programs that raise awareness of mental disorders and the importance of wellbeing and suicide prevention; - adopting and promoting programs to enhance help-seeking behaviour among high-risk groups and those who are least likely to seek help (e.g. young people, men, people from Aboriginal communities and people from culturally and linguistically diverse backgrounds); and - working to destigmatise conditions that contribute to suicide risk (e.g. mental illness, homelessness, financial hardship) with a view to encouraging help-seeking behaviour.

Action Area 3	Action Area 4
Improving community strength, resilience and capacity in suicide prevention	**Taking a coordinated approach to suicide prevention**
Action Area 3 will be achieved through:	Action Area 4 will be achieved through:
- raising awareness of the characteristics of healthy and resilient communities and supporting their development; - strengthening the capacity of families, schools, workplaces, religious groups and recreational and social groups to quickly identify and respond to indicators of potential suicidal behaviour; - developing and disseminating resources that recognise and support the important role of family, friends, colleagues and peers in suicide prevention; - educating communities to identify and respond to warning signs and risk factors for suicide; - working with mainstream, community and multilingual media to raise awareness about suicide prevention and how to responsibly cover related issues; - reducing the stigma and myths surrounding suicide by encouraging people to talk more openly about mental health problems and seek help early; and - supporting local groups and agencies to work together to reduce individual and community risks, strengthen protective factors and respond to crisis situations or major changes (e.g. drought and industry closures).	- coordinating suicide prevention initiatives across local, state and Commonwealth governments and between government, non-government and private sectors; - encouraging and resourcing integrated solutions to local suicide prevention needs; - developing practical tools for information sharing, including shared service agreements; - developing local data, outcome measures and joint service/client protocols; - improving information sharing and reducing duplication of services between governments, academic institutions, non-government organisations, and peak and professional bodies; - implementing a critical response model for communities experiencing early signs of crisis and the potential for an increase in suicide; - developing cross-government mechanisms to improve the integration of health, housing, community, justice, employment and other policies and programs for suicide prevention; - addressing the information and training needs of professional and community groups concerned with suicide prevention; - actively engaging local government in suicide prevention; and - strengthening local capacity by supporting the shared expertise of community and emergency services involved in suicide prevention.
Action Area 5	Action Area 6
Providing targeted suicide prevention activities	**Implementing standards and quality in suicide prevention**
Action Area 5 will be achieved through:	Action Area 6 will be achieved through:
developing Community Action Plans for communities within communities such as an isolated Aboriginal community or an institution such as a prison;	- developing and promoting standards for suicide prevention; - developing and promoting systematic evaluation models;

- developing and promoting innovative programs and supports for high-risk populations who traditionally do not access health services;
- making services more accessible and culturally secure;
- developing support systems for people who have attempted suicide and for their families;
- improving supports for people with mental health problems or mental illness who are at risk of suicide;
- supporting interventions that target high-risk groups;
- implementing guidelines, training and supports for frontline workers who routinely interact with high-risk groups;
- providing education and information for consumers and carers to identify and respond to suicidal behaviour;
- improving the emotional health of women and their families during pregnancy and the first postpartum year;
- implementing awareness-raising strategies to combat bullying and homophobia in schools;
- developing and promoting confidential peer support opportunities;
- educating and informing professionals, service providers, families and community organisations in the provision of safe and secure care environments for people at risk; and
- providing access to training in suicide prevention.

- promoting evaluation and research which builds the evidence base of suicide prevention and enhances practice;
- identifying the skills and training required to work effectively in suicide prevention;
- developing and maintaining timely, robust and transparent reporting systems to ensure that information on suicide programs is readily available;
- increasing information sharing on suicide prevention initiatives, to reduce duplication and promote good practice; and
- promoting and providing funding arrangements to support community responses to emerging needs.

Effective suicide prevention in Western Australia requires a coordinated approach across all levels of government and the whole of the community.

It is important for all government agencies to deliver integrated policies, programs and responses to improve suicide prevention.

The **Ministerial Council for Suicide Prevention** will lead the Strategy and oversee initiatives to improve strength and resilience, expand community knowledge of suicide, and support capacity building in communities at increased risk. Membership will include suicide prevention experts, community leaders, business leaders, government representatives and other important stakeholders.

A **non-government organisation** will be engaged to complete the daily work of the Ministerial Council for Suicide Prevention, including developing and implementing initiatives to increase awareness, and conducting research and evaluation.

Within the non-government organisation, positions of a **Network Coordinator** and an **Agency Coordinator** will be established. The Network Coordinator will identity and work with individual communities to engage them in suicide prevention initiatives. The Agency Coordinator will work with government, non-government and corporate sectors to develop and implement targeted strategies and policies to address and promote mental health and wellbeing.

For a time limited period, **Community Coordinators**, employed by an existing agency within the community, will work to identify existing services and resources, and gaps in services and resources. The Community Coordinators will develop and implement sustainable **Community Action Plans** (CAPs), in collaboration with the community, to address existing and emerging problems.

CAPs will identify high risk groups and intervention strategies for those groups, raise awareness of risk factors, promote mental health literacy, foster collaborative work at the community level, and improve access to support services.

CAPs will align with the action areas of the Strategy, be evidence based and have an agreed framework for evaluation. The non-government organisation will consider and refer each CAP to the Ministerial Council for Suicide Prevention, which will make recommendations to the Minister for Mental Health regarding funding for the proposed initiatives.

The structure for the implementation of the Strategy is illustrated below.

Western Australian Suicide Prevention Strategy Structure
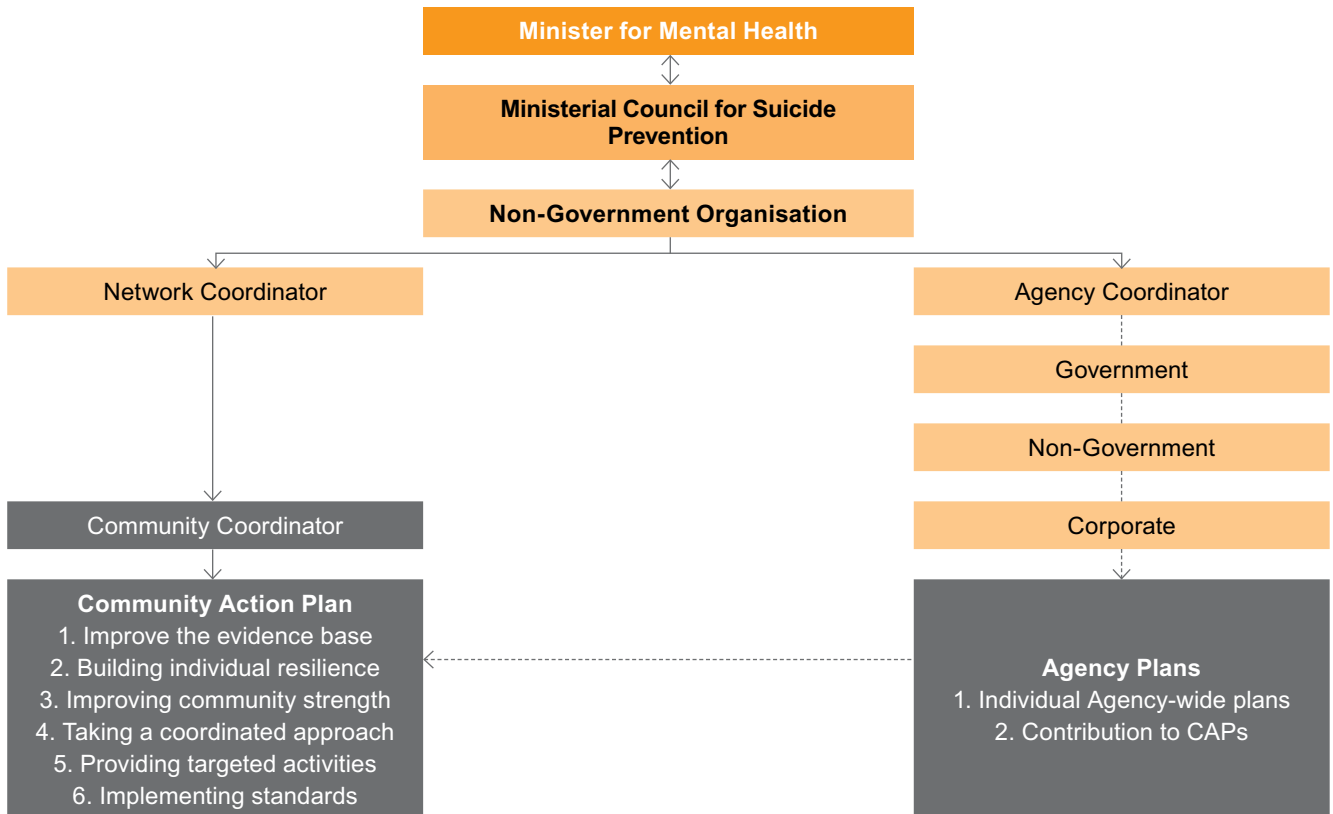
The Strategy will be implemented through State Government funding and has the capacity to attract and utilise additional financial resources from the non government sector.

The issue of suicide requires a comprehensive whole of government and whole of community approach. This approach depends on consistent and effective coordination and communication between a range of services and agencies. This Strategy provides the foundational framework for the State Government to coordinate and invest in suicide prevention strategies at all levels in the community.

Section 1: Overview
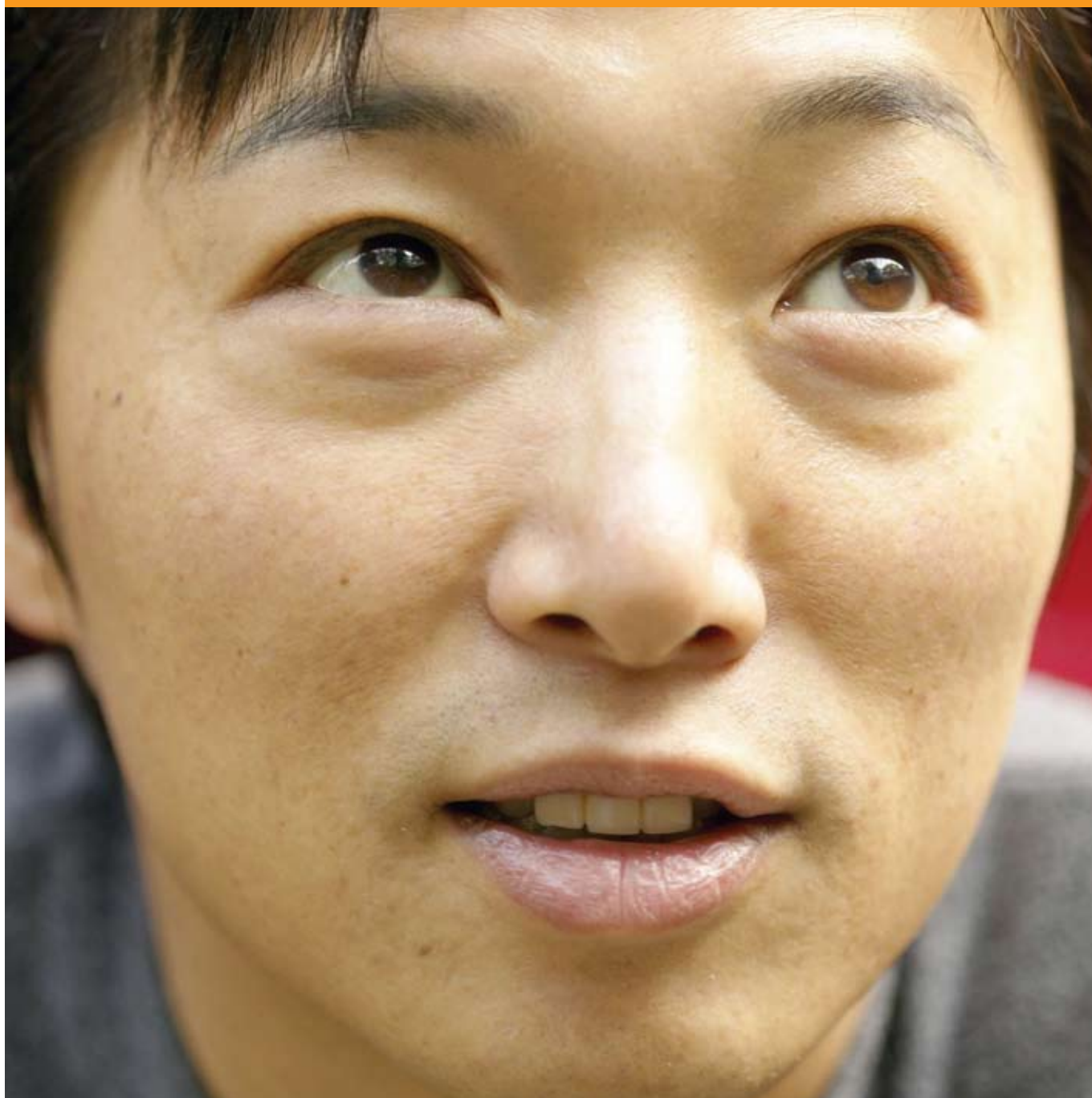
In the late 1980s, Western Australia was confronted with a rapid increase in suicide and suicidal behaviour among young people. As a result of this disturbing trend and in recognition of the seriousness of the issue, the State Government developed a youth suicide prevention strategy.[3]

More recently, concern has emerged in relation to increasing suicide rates among other social groups. As a result of this situation, there is growing recognition of the need for a comprehensive state suicide prevention strategy that provides a framework from which to coordinate initiatives and interventions across government and the community.

There is now clear evidence available that identifies both the risk and protective factors that are related to suicide and self-harm and the causal pathways that lead to these behaviours. Suicide is rarely the result of a single cause. In fact, a person's decision to take their own life follows the accumulation of and interaction between a number of associated risk factors.

The capacity to identify, influence and affect these factors is not the sole responsibility of any one agency, government department or discipline. In order to address the complex elements associated with suicide and suicidal behaviour and to effectively implement suicide prevention approaches, significant levels of collaboration, communication and contribution from governments, private and community organisations, individuals and families affected by suicide, as well as members of the wider community, are essential.

Purpose

The Strategy is a call to action. It aims to transform attitudes regarding suicide and suicidal behaviour and represents a guide for policies and services to better meet the needs of people at risk. The Strategy also charts a longer term vision to promote individual mental health and wellbeing and the need to enhance community capacity in approaches to suicide prevention.

This document outlines the governance structure for the implementation of the Strategy and the six Action Areas that will guide the work of the revised Ministerial Council for Suicide Prevention.

This Strategy provides Western Australia with a comprehensive framework to reduce suicide and self-harm.

The Strategy reflects a thorough analysis of almost 20 years of data on suicide and self-harm in Western Australia. It is aligned with the National Suicide Prevention Strategy and reflects findings from statewide consultations (see Appendix A).

Major themes from the Western Australian consultations

A whole-of-government approach is needed

- The commanding theme to emerge from community consultations in relation to suicide prevention is the need for a whole of government response to address the complex nature of suicide. An effective response to the issue of suicide and suicidal behaviour is not the responsibility of one single government department or agency.

- Government and non-government services need to be easier to understand, navigate and access.

Community, consumer and carer involvement is essential

- The family and friends of people who attempt suicide highlight that the burden for those at risk falls on their shoulders. It is therefore imperative that the perspectives and opinions of family and friends are included in suicide prevention plans.

- The types of support required can vary from person to person, and range from the need to access information only to the provision of intensive professional assistance.

Coordination of suicide prevention activities needs to be strengthened

- The coordination of suicide prevention initiatives is essential, particularly in response to emerging suicide clusters.

- There is a strong call for government departments and other key stakeholders to clearly articulate their roles and responsibilities in relation to suicide prevention.

Rural and remote areas face specific challenges

- A criticism from non-metropolitan areas was that social planning and interventions tend to be developed in the city and then exported to rural and remote areas, with questionable effectiveness.

- Networking and collaboration is essential in suicide prevention to address local challenges.

Aboriginal suicide prevention initiatives must be a priority

- Culturally secure responses to suicide and suicide behaviour are essential for Aboriginal Western Australians who experience disproportionate rates of suicide in comparison to non-Aboriginal Western Australians.

Additional issues discussed in each region are detailed in the "Report on Consultation Process", September 2007 available on the Ministerial Council for Suicide Prevention website.[4]

Section 2: Data
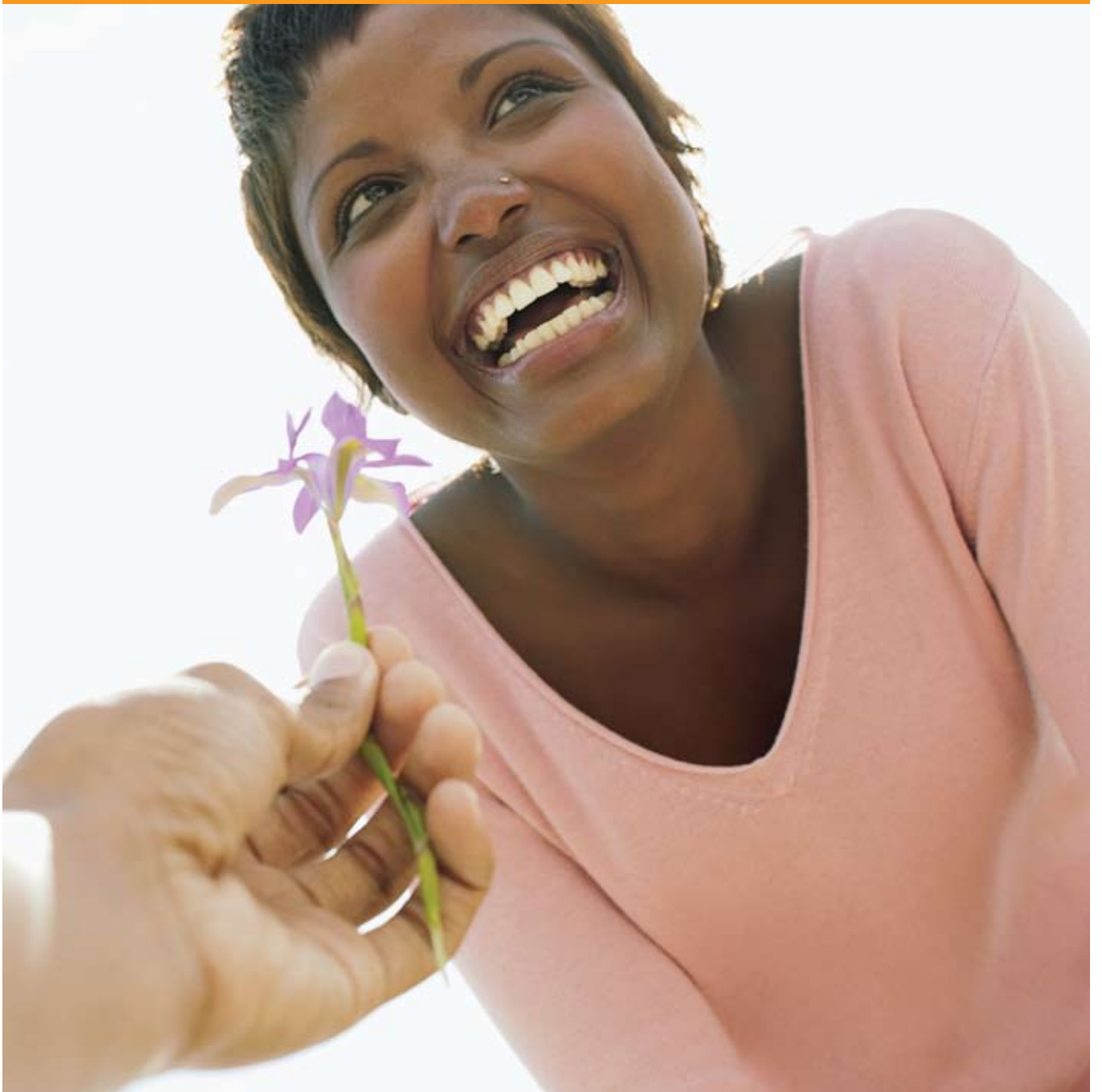
International data

The World Health Organization estimates that in the year 2000, there were approximately one million suicide deaths and up to 20 million suicide attempts worldwide. Suicide is now one of the three leading causes of deaths among males and females aged 15-44 years.[5]

Australia has the eleventh lowest recorded rate of suicide of the 30 Organisation for Economic Cooperation and Development (OECD) nations.

Table 1 presents the combined male and female suicide rates for countries worldwide that provide data to the World Health Organization.

Table 1: International age standardised suicide rates, 2002[6]

Country	Rate per 100,000
Greece	2.8
Italy	5.0
Brazil	5.4
Spain	6.3
Netherlands	7.4
United Kingdom	7.8
Malaysia	8.0
United States of America	9.5
Singapore	9.8
Argentina	10.2
Australia	10.4
Sweden	10.4
Canada	10.6
Germany	10.6
Norway	10.7
Denmark	10.9
Ireland	11.1
Chile	11.5
New Zealand	12.2
France	13.2
Cuba	13.5
Switzerland	13.5
Austria	14.3
Poland	15.2
Korean Republic	17.2
Belgium	17.6
Japan	18.7
Finland	20.6
Hungary	22.7
Russian Federation	36.0

Suicide in Australia

In 2006, 1,799 suicide deaths were registered in Australia. From 2003 to 2007, the combined annual suicide rate for men and women was 9.8 per 100,000.

The following table provides data on suicide deaths in each state and territory in 2006. Tasmania had the highest suicide rate, followed by the Northern Territory and South Australia. The lowest rates were in New South Wales and Queensland. Western Australia's suicide rate remained higher than the national rate, at 10 per 100,000.

Table 2: Suicide by State and Territory, 2006[7]

State	Suicide Deaths			
	Males	**Females**	**Persons**	**Rate per 100,000**
New South Wales	401	103	504	7.3
Victoria	332	112	444	8.5
Queensland	278	62	340	8.3
South Australia	129	41	170	10.7
Western Australia	156	51	207	10.0
Tasmania	55	18	73	14.7
Northern Territory	26	3	29	13.0
Australian Capital Territory	21	11	32	9.5
Total	1398	401	1799	8.6

Australia is recognised as having one of the highest ratios of male to female suicides (approximately 4:1) compared with other countries.

While suicide accounts for 1.6% of all deaths, it accounts for a much higher proportion of deaths within specific age groups. This is particularly evident in men aged 20–25 years, where 1 in 5 deaths are due to suicide.

Suicide rates for men aged 25–34 increased steadily from the early 1990s. Although rates have decreased in recent years, youth suicide remains a major concern.

Figure 1: Male age-specific suicide rates, Australia, 1988-2006 (ABS 2008)[8]
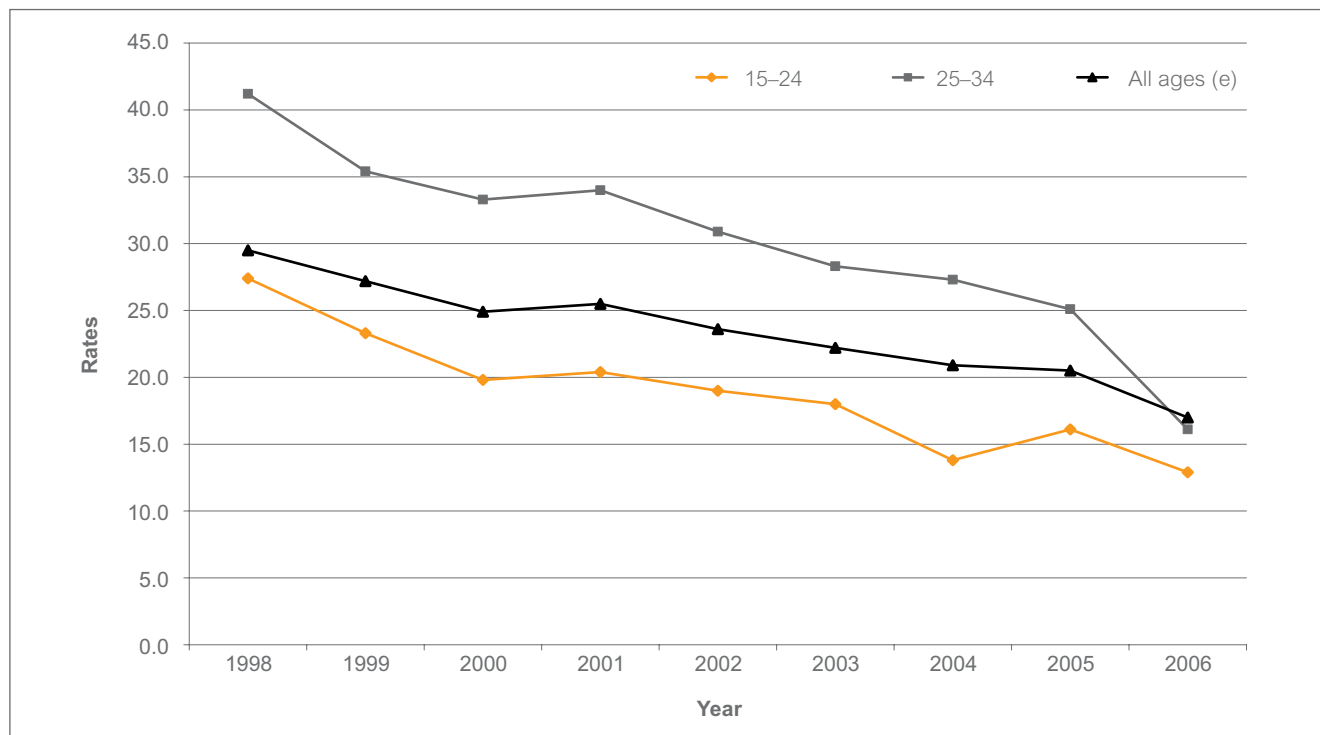
The phenomenon of under-reporting of suicide rates has attracted a lot of attention in literature for many years particularly in relation to single vehicle car accidents. The real percentage of suicides among car accidents is not reliably known; studies by suicide researchers suggest that vehicular fatalities that are suicides vary from 1.6% to 5%.[9]

Suicide in Western Australia

In 1986, Western Australia was the first state to record demographic, clinical and forensic details associated with suicide deaths. The resulting data collection, known as the Western Australian Coroner's Database, provides a valuable source of information in relation to trends in suicide and self-harm in Western Australia. These data are more accurate than the Australian Bureau of Statistics data as completed suicides are recorded in the year that they occurred rather than in the year that the Coroner makes a determination which, in some cases, can take several years.

The Coroner determined that in the period 1982-2006, a total of 4,787 deaths in Western Australia occurred as a result of suicide. Of this number, 3,840 were men and 947 were women.

Figure 2: Age-standardised rates of suicide by gender, Western Australia, 1986-2006[10]
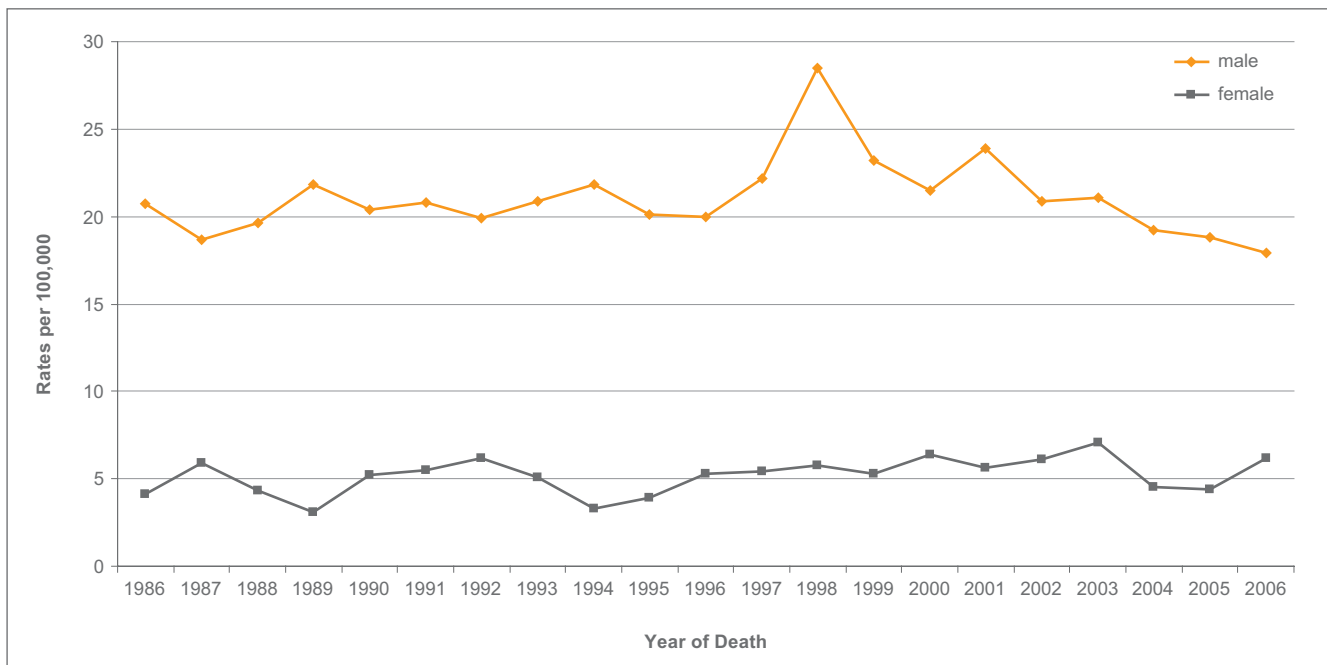
Suicide rates peaked in 1998 with a total of 313 deaths. Since then, there has been a steady decline in the annual number of suicides in Western Australia. The 2005 rate of 11.5 per 100,000 represents the lowest rate of suicide recorded since the development of the Western Australian Coroner's Database in 1986.

Methods used

Understanding methods of suicide can inform prevention strategies by altering access to the means of suicide.

Between 1986 and 2006, the most common methods of suicide used by Western Australian men of all ages were hanging and carbon monoxide poisoning. Since 1986, there has been a ten-fold increase in hanging and a decrease in carbon monoxide poisoning. While the use of firearms as a method of suicide was more common in rural areas,[11] legislation introduced in 1996 restricting the availability of firearms has resulted in approximately ten less firearms-related deaths per year.[12]

In 2006, hanging was the most common method of suicide used by women, with data illustrating significant increases in the rates of hanging since 1995, and an increasing trend by women to use more 'active' methods of self-inflicted injury. Prior to this time, self-poisoning was the most commonly used method by women of all ages.

Priority groups

Men

The Coroner's Database reveals that men most at risk of suicide are:

- aged 20–34 years and 75 years and over — suicides among men aged 20–34 years account for 40% of all male suicide deaths;
- Aboriginal;
- living in rural and remote areas; and/or
- in custody.

Life events such as relationship breakdowns, mental illness, substance misuse, conflict with family or friends, financial issues and physical illness were the most commonly reported stressors for men who suicided.

Recent research on suicide among men aged 18–34 years found that low levels of mental health literacy, reluctance to seek help and negative perceptions of service providers and professionals were significant issues for men who had been suicidal.[13]

Age

From 1986 to 2006, the statewide suicide rate for men was highest among those aged 20–24 years (36.1 per 100,000).[14] Recent trends indicate a decrease in suicide rates in this group since 1998. Following the decline in youth suicide rates, elevated rates have been observed among those aged 25–34 years. There is evidence of a 'cohort effect' where the birth cohort of men who experienced high rates of suicide in their 20s continued to have relatively higher rates, as a group, as they entered their 30s and early 40s.

In 2006, the suicide rate for men was highest among those aged 85 years and over (56.6 per 100,000). Caution should be taken when interpreting the age-specific data due to the small population numbers in this age group.

Over the past two decades, the highest rates of completed suicides by women were those aged 40–49 years (7.8 per 100,000). Although, in 2006, the suicide rate for women was highest among the 35–39 year age group (11.8 per 100,000).

A total of 507 people (388 men and 119 women) aged 65 or older took their own lives between 1986 and 2006. During this time there has been a significant reduction in the rates of suicide among the elderly, from 20.1 per 100,000 in 1986 to 12 per 100,000 in 2006. This is believed to reflect improved diagnosis and effective treatment for depression and other mental health disorders that affect older people.

Over the next 20 years the proportion of Western Australia's population over the age of 65 years will increase significantly. As a consequence, the number of elderly people living on their own with higher care needs will also increase. This situation will require significant changes in the approach taken in mental health promotion and suicide prevention strategies for this age group.

Aboriginal Australians

Suicide is believed to have been uncommon among Aboriginal communities in pre-colonial times. Since the late 1970s, the rising incidence of suicide and other self-inflicted injuries has become a serious issue.[15] This increase coincides with a decline in traditional Aboriginal ways of life and a deterioration of the social environment in many communities. The 1991 Royal Commission into Aboriginal Deaths in Custody exemplified that the lives of 99 Aboriginal men who died in custody Australia-wide were characterised as having high rates of unemployment; low levels of formal education; histories of childhood separation from families; police records from an early age and alcohol abuse.[16]

From 1986 to 2006, 304 Aboriginal suicides were recorded in Western Australia. Of these suicides, 261 were men and 43 were women. Almost two thirds (62%) of Aboriginal men who completed suicide were under the age of 30, compared to 32% for non-Aboriginal men. During the same period, the suicide rate among Aboriginal men aged 20-29 years was 107.8 per 100,000, more than three times the comparable rate for non-Aboriginal men.[17] The rate of suicide among Aboriginal men increased dramatically from 4.7 per 100,000 in 1986 to 78.8 per 100,000 in 1999 and then declined to 68.4 per 100,000 in 2006.[18] This coincided with increased Western Australian and Commonwealth resources to assist Aboriginal communities to tackle the issue. Suicide remains seven times more prevalent among Aboriginal men than Aboriginal women.

In 2007 and 2008, the Coroner's inquests into the high number of Aboriginal deaths in the Kimberley, as well as the reports to the Coroner's Office of increased possible suicides in Perth and the South West, suggests a recent increase in Aboriginal suicide. The full extent of this increase can only be determined when the complete annual suicide figures are available from the Coroner's Office. The emergence of suicide clusters* in Aboriginal communities is of particular concern and requires a coordinated culturally secure response.

---

* A suicide cluster may be loosely defined as a number of suicides and/or suicide attempts occurring close together in time and space in a community. However, there is currently no generally agreed upon operational or statistical definition of a suicide cluster.

Migrants

According to data from the Australian Bureau of Statistics, 23% of the Australian population was born overseas. A study by Kryios[19] indicates that about 25% of suicides in Australia are by people within the migrant population, with 60% of these deaths occurring among people from a non-English speaking background.

In general, suicide rates follow the country of birth rather than the country of settlement, with migrants from countries with high rates of suicide also experiencing high rates in Australia. This includes people from English-speaking countries; such as western, northern, eastern Europe, and the former USSR. Migrants from countries with low rates of suicide generally have low rates in Australia, which includes people from southern Europe, the Middle East and Asia.[20] Similar patterns are evident in Western Australia. Suicide rates among migrant groups in Australia are generally higher than in the country of birth.[21] Migrants aged 65 and older have higher rates than the overall population.[22]

Rural and remote areas of Western Australia

In Western Australia between 1986 and 2006, the suicide rate for men in the rural areas increased. The factors that influenced this increase include financial stress; increased unemployment; social and geographic isolation; difficulties accessing services; and greater availability of means of lethal self-harm.[23]

Annual suicide rates in rural and remote areas can vary considerably due to the small population numbers in these areas. Significantly high suicide rates among men were evident in the Kimberley and Goldfields areas, at 2.0 and 1.4 times greater than the state average respectively. This is partly due to an increased proportion of suicide rates among Aboriginal people, particularly in the Kimberley region.

In the period 1986 to 2006, the suicide rate for men in remote areas was 27.7 per 100,000, compared to 19.8 per 100,000 for men in the metropolitan area.

Prisons

Suicide is the leading cause of death in Australia's correctional institutions and accounts for almost half of all prison deaths.[24] From 1986 to 2006, 66 suicides—of which 65 were men—were recorded in Western Australian prisons. The suicide rate of Aboriginal people in custody was lower than the rate for non-Aboriginal prisoners.

Between 2001 and 2006, the suicide rate for men in Western Australian prisons was over five times higher than the general population. Higher suicide rates were evident among people on remand than those of sentenced prisoners. This is consistent with studies that indicate higher levels of emotional distress among people in the early stages of custody and in the first few weeks of incarceration. This signifies that the identification of risk in people on remand or people who are newly sentenced, is essential.[25]

Human service agency involvement

A study conducted by NSW Health[26] found that 15% of children and young people in New South Wales who completed suicide had been clients of the Department of Community Services at some stage of their lives. A similar New Zealand study found that over 60% of teenagers who took their own lives were registered with statutory child protection or juvenile justice services.[27] These findings highlight the need for agencies to screen for mental health and suicide risk in their assessment and care of young people.

Individuals and families bereaved by suicide

Suicide has a profound effect on the family and friends of the deceased. Research suggests that family and friends who are bereaved by suicide are at a two- to five-fold higher risk of suicide compared to the general population.[28] Where suicide has happened among already vulnerable groups, such as Aboriginal Australians, the already high risk of suicidal death experienced by members of such groups is compounded.

Same-sex attracted young people

Conflicting societal norms, victimisation, marginalisation and the fear of discrimination can lead to increased levels of psychological distress, self-harm, anxiety, depression and suicide.[29]

Australian research indicates that same-sex attracted young people may be up to six times more likely to attempt suicide than the general population. Higher rates of suicide are also associated with transgender youth.[30]

Associated risk factors

There is no single and identifiable cause of suicide. Suicide and suicidal behaviour involves a complex interaction and interplay between biological, psychological, social and cultural factors. The Western Australian Coroner's Database reports on the precipitating stressors that lead to suicide and provides valuable insight into how best to intervene with those people at risk. The following table illustrates the most frequently recorded stressors for Western Australian men and women. It should be noted that these stressors may not be the sole cause of a suicide, but may represent contributing factors in the decision to suicide.

Figure 3: Precipitating stressors among those who completed suicide according to gender, Western Australia, 1986-2006[31]
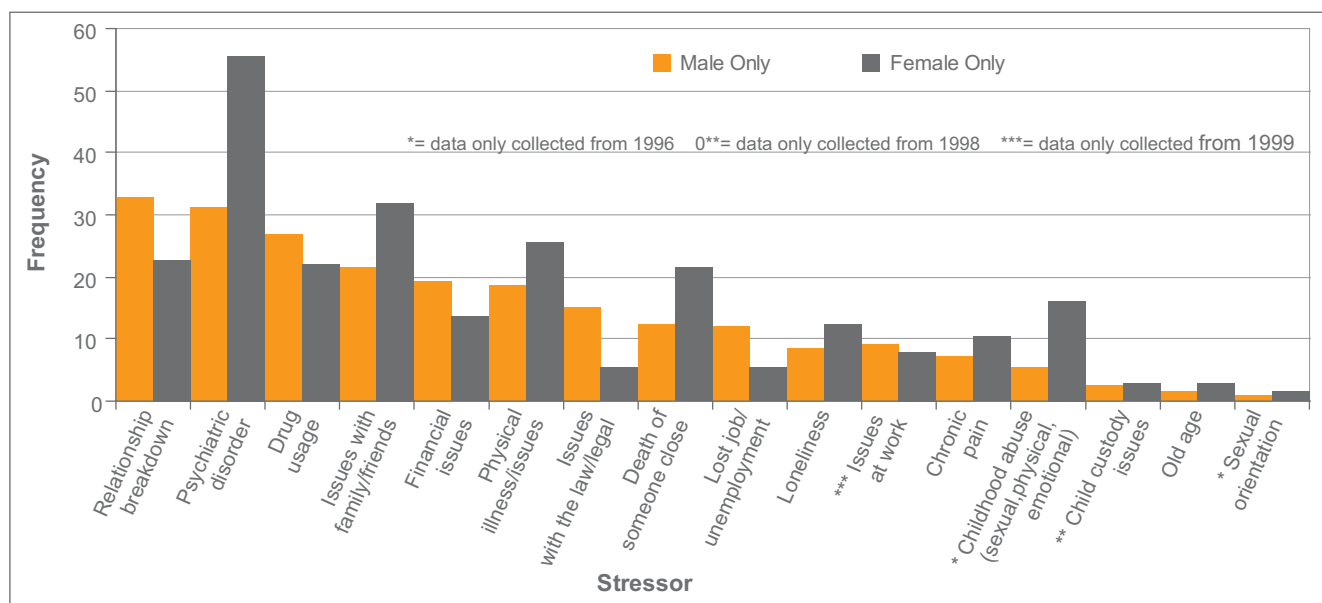
Psychiatric disorders

In Western Australia over the past 21 years, 35% of men and 60% of women who completed suicide had suffered from a diagnosed psychiatric disorder in the preceding 12 months. These disorders included depressive disorders, schizophrenia, substance misuse and personality and other adjustment disorders. The observations of family and friends of those who completed suicide indicate that 57% of men and 66% of women exhibited symptoms of depression in the three months preceding their deaths.[32]

Over a third of Western Australian men who completed suicide between 1986 and 2005 had been admitted to a psychiatric hospital or a public hospital for psychiatric treatment at some time in their lives. Of these men, 15% completed suicide on the day of discharge from their last admission, whether they were an inpatient or on day-release. Similarly, one fifth of Western Australian women completed suicide on the day of discharge, and a third within a month of discharge.

Perinatal mental health

Mental health problems in women are common during pregnancy and after childbirth. Research has highlighted that psychiatric disorders are a significant risk factor for suicide and identify suicide as one of the leading cause of maternal death.[33]

Women at highest risk for perinatal mental health disorders are those with an individual or family history of mental health disorders such as depression, anxiety or panic disorders. However, it should be noted that perinatal mental health disorders can occur in women without any past history or complications in pregnancy.

Self-inflicted injury and suicide

As hospitalisation data only record cases where self-inflicted injury resulted in hospitalisation, it is difficult to ascertain an accurate number of suicide attempts. Clinical case notes need to outline whether it was considered that the patient's intent was to end their life, as opposed to inflicting non-lethal harm. Evidence indicates that a significant proportion of suicide attempts do not come to medical attention.[34]

Western Australian hospitalisation data indicates that in 2006, 3,182 people were admitted to public and private hospitals following self-inflicted injury (2,014 females and 1,168 males). The highest admissions for both men and women occurred in people aged 15-24 years. The increasing frequency of self-inflicted injuries in 10-14-year-olds in recent years is an emerging concern.[35]

Between 1986 and 2006, 31% of men and over half of women who completed suicide had previously been hospitalised for self-inflicted injuries. The proportion of men who completed suicide with a previous history of hospitalisation for self-inflicted injury has increased in recent years—particularly among those aged 30-34 years. Another Western Australian study[36] found that 25% of men and over 50% of women had previously recorded hospitalisations for self-inflicted injury prior to the self-injury that resulted in their death. The study also found that people admitted to hospital for such self-injury were 20 times more likely than the general population to eventually die by suicide.

Alcohol and other drugs

Increased alcohol and other drug use frequently occur in the weeks and months before suicide. The proportion of Western Australian men and women who had a substance abuse problem at the time of taking their own lives has increased substantially from 35.9% in 2002, to 44.8% in 2006. Between 1986 and 2006, 32% of men and 25% of women had experienced harmful substance use within three months before their death. Alcohol and cannabis were the most commonly used substances among men who had substance misuse issues at the time of their death. For women, the most commonly used substances were alcohol and amphetamines.

In the period 1986 and 2006, positive blood alcohol readings were present in 41% of men and 27% of women who completed suicide. In over 70% of these cases, the reading was equal to or greater than 0.05.

The increased risk of suicide from alcohol and other drug use is linked to changes in behaviour such as disinhibition and the triggering of acute psychiatric reactions. Long-term use and/or dependency is also associated with increasing stress that may trigger or intensify existing mental health disorders.[37]

Socio-economic status

The Coroner's Database[38] illustrates that the overall occurrence of suicide extends across socio-economic groupings. Suicide rates are higher for disadvantaged socio-economic groups and for women in the highest 20% of socio-economic advantage. These results highlight a distinct need for a range of preventative strategies that target all sectors of society.

Section 3: A framework for prevention
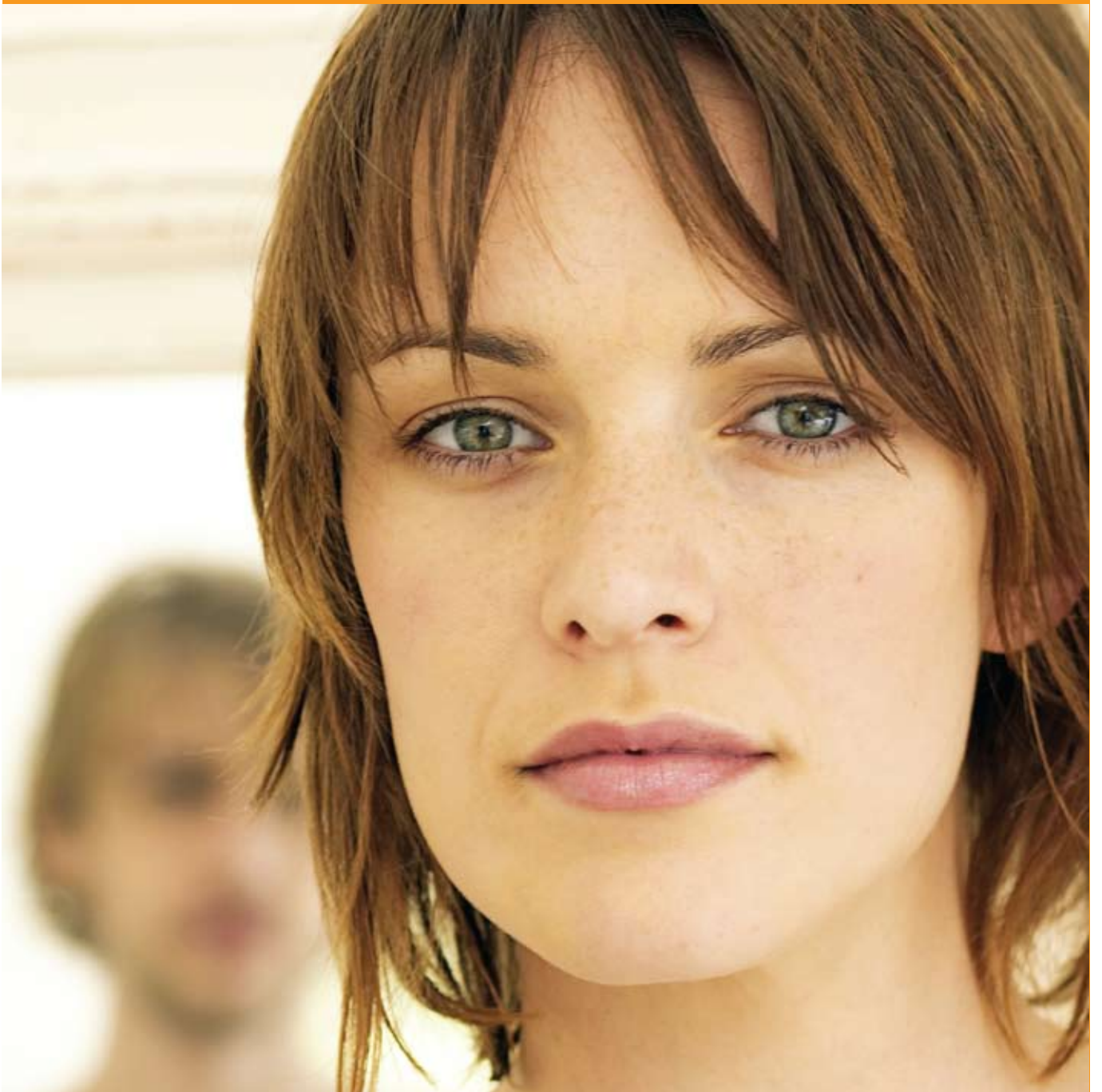
Our present understanding of suicidal behaviour recognises the importance of two sets of risk factors associated with suicide and suicide behaviour. The first are proximal or immediate factors, which are events that often act as precipitants to suicide, such as severe depression, loss of a job or a loved one and drug or alcohol intoxication. The second are longer term or distal factors, which have a cumulative effect and often stem from early childhood and are thought to represent the foundation on which immediate risk factors are either managed successfully or unsuccessfully. These include childhood neglect and trauma, home environment, family history of suicide and impulsivity and a lack of interpersonal support.

Figure 4: Risk factors associated with suicide and suicide behaviour[39]
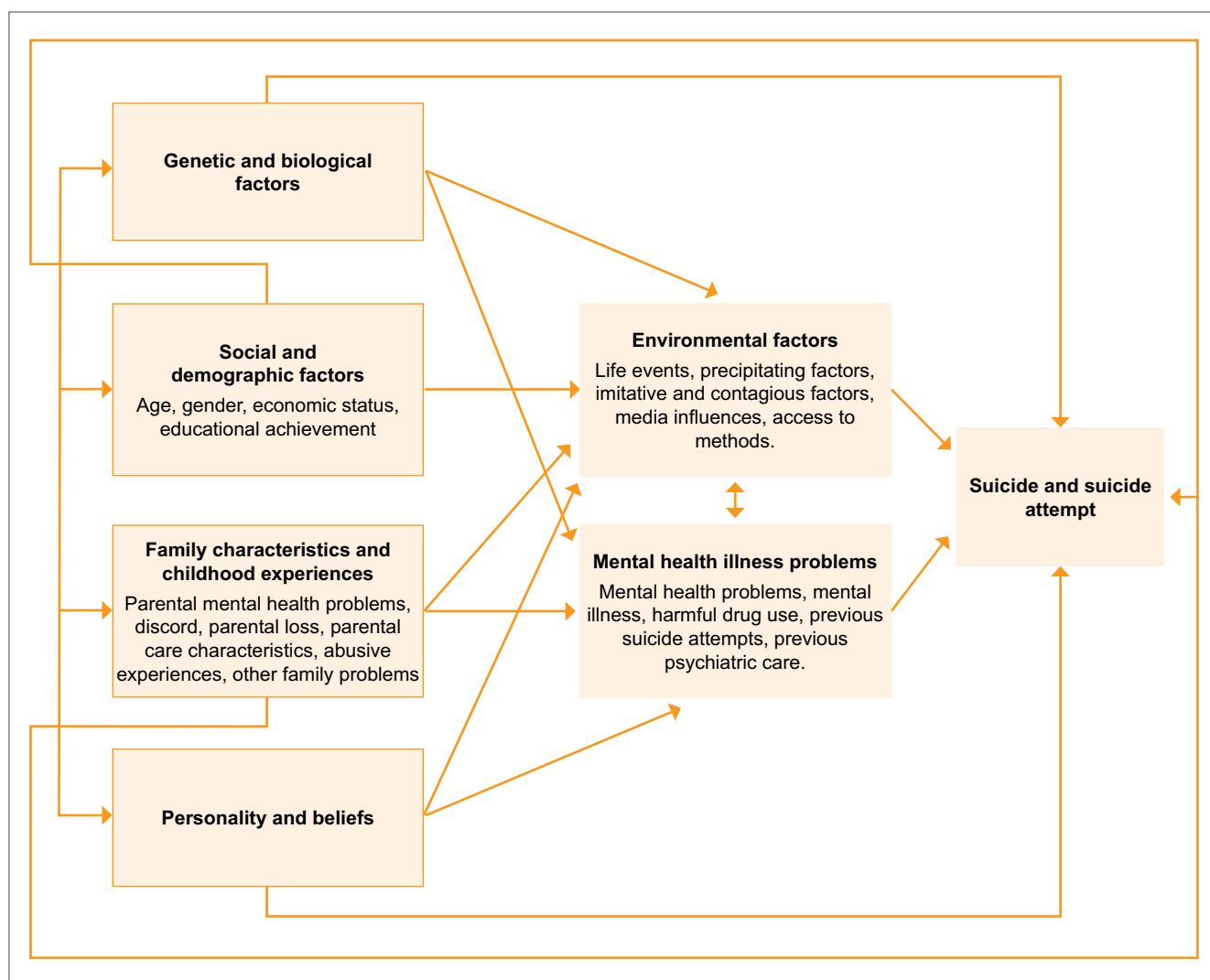
Determining which individuals will become suicidal as a result of either immediate or longer term factors is extremely difficult. Therefore, wide-ranging prevention strategies and interventions are needed to counter the effects of both sets of risks. Population-based approaches, targeted interventions for high-risk groups and initiatives that respond to people in crises are all required to reduce the rate of suicide.

Table 3: Examples of Risk and Protective Factors[40]

	Risk Factors for Suicide	Protective factors for suicide
Individual	Gender (male) Mental illness or disorder Chronic pain or illness Immobility Alcohol and other drug problems Low self-esteem Little sense of control over life circumstances Lack of meaning and purpose in life Poor coping skills Hopelessness Guilt and shame	Gender (female) Mental health and wellbeing Good physical health Physical ability to move about freely No alcohol or other drug problems Positive sense of self Sense of control over life is circumstances Sense of meaning and purpose in life Good coping skills Positive outlook and attitude to life Absence of guilt and shame
Social	Abuse and violence Family dispute, conflict and dysfunction Separation and loss Peer rejection Social isolation Imprisonment Poor communication skills Family history of suicide or mental illness	Physical and emotional security Family harmony Supportive and caring parents/family Supportive social relationships Sense of social connection sense of self-determination Good communication skills No family history of suicide or mental illness
Contextual	Neighbourhood violence and crime Poverty Unemployment, economic insecurity Homelessness School failure Social or cultural discrimination Exposure to environmental stressors Lack of support services	Safe and secure living environment Financial security Employment Safe and affordable housing Positive educational experience Fair and tolerant community Little exposure to environmental stressors Access to support services

Population-based approaches to suicide prevention are premised on an understanding that mental health is influenced by a range of environmental and bio-psychosocial influences. Population-based strategies aim to strengthen protective factors in the family and community and, therefore, decrease the likelihood that an individual will respond to adverse life circumstances with suicidal behaviour. Activities that help build self-esteem, psychological strength and personal competence are necessary components of this approach. Robust public policy that promotes the critical importance of early childhood and adolescent well-being is also required.

Interventions for high-risk groups focus on engaging and supporting individuals and communities who may be at higher risk. Such interventions may involve outreach services that directly engage those individuals or communities that often do not relate effectively with mainstream services.

Preventative interventions for people in crises tend to be more clinical and individual in their focus and consist of initiatives that directly prevent people from attempting suicide. These interventions aim to improve access to assessment and specialist care, by ensuring that services are available at the right place, at the right time and use the right approach.

Mrazek and Haggerty's model[41] provides a useful way to conceptualise suicide prevention. Within this model interventions range from prevention strategies through to treatment, rehabilitation and longer term care.

Figure 5: The spectrum of interventions for mental health problems and mental disorders[42]
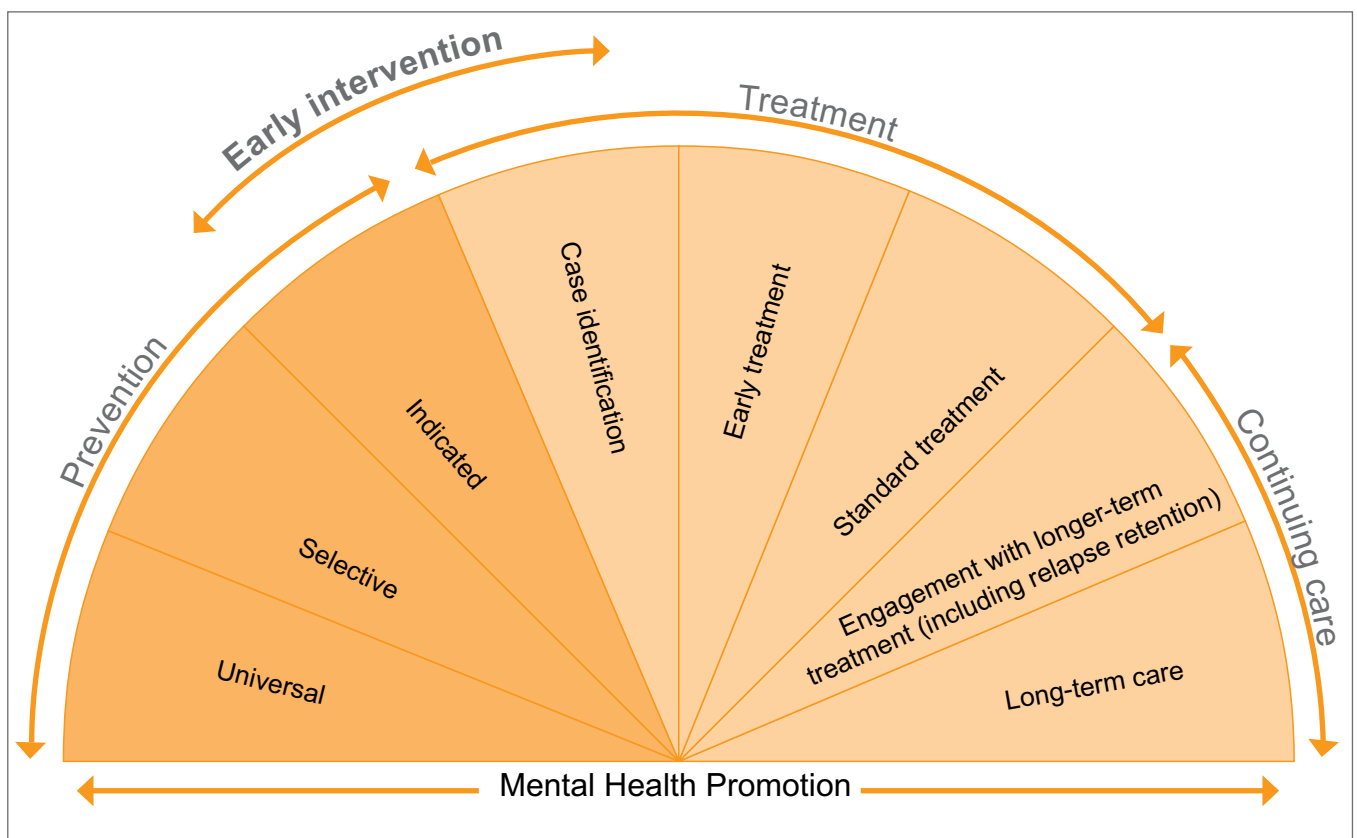
Universal prevention strategies promote strong, resilient communities and focus on improving the mental health of the population. These strategies may include primary preventative activities that affect the whole population such as reducing access to the means of suicide.

Selective prevention strategies target at risk groups such as Aboriginal youth, children of parents who have suicided or had a substance abuse problem and/or children growing up with domestic violence.

Indicated prevention strategies target individuals who have symptoms of or are at the highest risk of suicide, such as young people experiencing depression or people who have attempted suicide.

Case identification/early treatment strategies involve the early recognition and response to people who are currently at risk of suicide.

Standard treatment strategies provide access to services for people exhibiting suicidal behaviour or who have attempted suicide, including those who are hospitalised.

Relapse prevention and longer term treatment strategies aim to prevent recurring suicidal behaviour and hospitalisation by engaging with people who are at chronic risk of suicide or who repetitively self-harm.

Prevention strategies can be targeted universally at the general population, they can focus on selective at-risk groups or they can be directed to those at risk as required.

This strategy is focused on the prevention aspects of this model. However the Ministerial Council for Suicide Prevention will advocate for greater accountability from all agencies and service providers who have a role to play in reducing suicide.

The complex nature of suicide means there is no one simple solution. It requires concerted action on many fronts and a strategic framework to integrate these efforts.

Section 4: The way forward in Western Australia

The National Suicide Prevention Strategy: *Living is for Everyone* (LIFE) offers a framework from which new suicide prevention initiatives will be developed and delivered in Western Australia.

1. Suicide prevention is a shared responsibility across:

   - government and non-government agencies;

   - the private sector;

   - professional groups; and

   - the wider community (including families and friends).

2. Information, service and support should be provided at the right time and when these elements can best be received, understood and applied.

3. Activities should include access to clinical or professional treatment for those in crisis and support for people who are recovering and returning to community life.

4. Activities must be appropriate to the social and cultural needs of the individuals, groups or populations being served.

5. Activities should be designed and implemented to target and involve:

   - the whole community;

   - communities and groups that are most at risk of suicide; and

   - individuals at risk of suicide.

6. Activities need to be located at places and in environments where the target groups are comfortable and at ease and where activities will be accessible and within reach to those who need them most.

7. Local suicide prevention activities must become sustainable to ensure continuity and consistency of services.

8. Suicide prevention activities should aim to be evidence based, outcome focused and independently evaluated.

9. Suicide prevention activities must not be harmful. A small number of activities that aim to protect against suicide have the potential to increase suicide risk among vulnerable groups. Therefore, activities need to address and respect the context, health, receptivity and needs of the person at risk.

10. Activities need to be sensitive to the broad factors that influence suicide risk—the social, environmental, cultural and economic factors that contribute to quality of life and its opportunities—and how these factors vary across cultures, interest groups, individuals, families and communities.

11. Services for people who are recognised as at risk should reflect a multi-disciplinary approach and provide a safe, caring and understanding environment.

Implementing the Western Australian Suicide Prevention Strategy

Effective suicide prevention in Western Australia requires a coordinated whole of government and whole of community response.

To achieve and maximise effective and positive outcomes in suicide prevention, the issue will be prioritised by all government departments to ensure that suicide prevention is given the whole of government support and the strategic coordination that is required. Through Cabinet, the Minister for Mental Health will ensure that government departments work collaboratively to improve the integration of policy, programs and immediate responses for improved suicide prevention.

Ministerial Council for Suicide Prevention

The Minister for Mental Health will give new direction and responsibility to the suicide prevention experts, community and corporate leaders, government departments, professionals and people impacted by suicide who constitute the revised Ministerial Council for Suicide Prevention.

The Ministerial Council for Suicide Prevention will oversee initiatives to improve individual strength and resilience, extend community knowledge and understanding of suicide and suicide behaviour and identify communities that require additional support to build capacity in suicide prevention. The Ministerial Council for Suicide Prevention will also:

- advise on the development of targeted suicide prevention activities for high-risk populations;
- promote suicide prevention information and resources; and
- recommend research priorities, standards and quality measurements in suicide prevention across departments and agencies.

Using existing recurrent resources, a non-government organisation will be appointed to undertake the day to day work of the Ministerial Council for Suicide Prevention. This work will include developing and delivering innovative approaches to increase public awareness, and, overseeing research, evaluation, education and training in suicide prevention.

The non-government organisation will provide leadership and coordination in response to emerging clusters of suicides. If a suicide cluster occurs in an Aboriginal community, the non-government organisation will lead culturally sensitive community and agency responses that support and respect the differences between specific Aboriginal groups. This critical work will be undertaken with support from agencies such as the Department of Indigenous Affairs.

The appointed non-government organisation will also work across communities and agencies to improve community strength and individual capacity in preventing suicide. From within the non-government organisation, a Network Coordinator will contract individual communities to play a part in implementing the Strategy and an Agency Coordinator will engage government, non-government and corporate agencies to establish organisation-wide suicide prevention strategies, mobilise resources to produce sustainable strategies and create agency wide commitment for prevention initiatives.

Workplaces have a vital role to play in providing supportive environments that promote wellbeing and resilience. With support from the Agency Coordinator, industry, business and government agencies will implement suicide prevention initiatives and resilience building programs for employees. In additon the Agency Coordinator will encourage and support government and corporate agencies to contribute to the development and implementation of Community Action Plans.

Community Coordinators

Employed by a local agency, a network of Community Coordinators will work within communities to identify and map existing suicide prevention activities and determine the need for new initiatives.
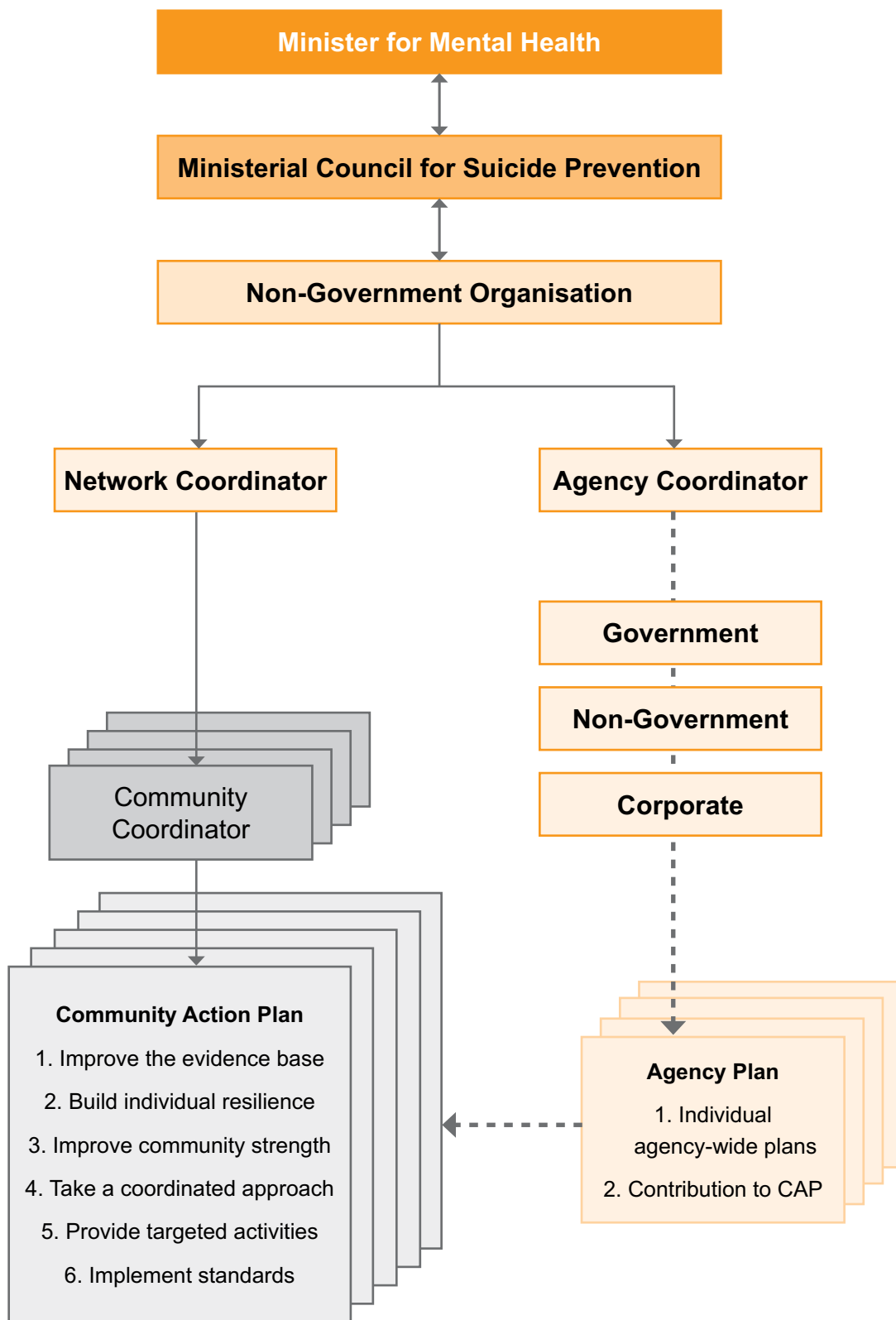
Community Coordinators reporting to and supported by the appointed non-government organisation on agreed program and financial performance measures will lead the development, implementation and sustainability of a Community Action Plan.

Each Community Action Plan will:

- be sustainable and align with the Action Areas of the Strategy;
- map existing suicide prevention activities and determine the need for new initiatives;
- identify high-risk groups in the community and outline strategies for intervention that are acceptable to and address their particular needs;
- raise awareness of the risk factors associated with suicidal behaviour;
- promote mental health literacy and help-seeking;
- outline how individuals, groups and organisations can work more collaboratively to reduce the suicide rate;
- address the needs of specific groups for example, Aboriginal communities, hospitals, universities and prisons;
- improve knowledge of and access to appropriate support services; and
- have an agreed evaluation framework.

The non-government organisation will work with each community to ensure that their Community Action Plan is evidence based and aligned with the Action Areas of the Strategy. The non-government organisation will consider each Community Action Plan and make recommendations to the Ministerial Council for Suicide Prevention regarding funding for suicide prevention initiatives.

Figure 6: Western Australian suicide prevention structure

Minister for Mental Health

Ministerial Council for Suicide Prevention

Non-Government Organisation

Network Coordinator

Agency Coordinator

Government

Non-Government

Corporate

Community Coordinator

Community Action Plan

1. Improve the evidence base

2. Build individual resilience

3. Improve community strength

4. Take a coordinated approach

5. Provide targeted activities

6. Implement standards

Agency Plan

1. Individual agency-wide plans

2. Contribution to CAP

Section 5: Action Areas

The LIFE framework comprises six Action Areas that provide the parameters within which future initiatives and programs will be developed to reduce the suicide rate.

Action Area 1. Improving the evidence base and understanding of suicide prevention

The complexity and changing nature of suicidal behaviour necessitates that up-to-date research and evaluation measures inform and direct prevention strategies and training.

The Commonwealth Government Department of Health and Ageing recently commissioned a national review of the research on suicide prevention. One of the recommendations of this review suggested extending the scope of research beyond epidemiological surveillance to include a stronger focus on evaluating the effectiveness of suicide prevention interventions. In Western Australia, several major projects funded as part of the National Suicide Prevention Strategy are due for completion in 2009 (See Appendix B). Findings from the evaluation of these activities must be used to inform future initiatives.

Action Area 1 will be achieved through:

- undertaking targeted research and evaluation on suicide and suicide prevention;
- developing the evidence base to better understanding the warning signs, tipping points and risk factors for suicide;
- improving the evidence base regarding community capacity and resilience-building for the prevention of suicide; and
- improving the understanding of the most effective interventions for Aboriginal communities.

Action Area 2. Building individual resilience and the capacity for self help

A comprehensive approach to reducing suicidal behaviour needs to include strategies that foster individual resilience and promote community, family, school and workplace environments as avenues of social support.

Peer support programs improve protective factors and are based on the premise that people with similar experiences can provide empathy, validation and practical advice to others. These programs are particularly beneficial in schools and universities to develop young people's social and emotional skills; foster positive peer relationships; and encourage help-seeking behaviours.

In recent years, a number of industries have adopted peer support programs to enhance the resilience of apprentices and other workers. In Western Australia, peer-based programs are currently being delivered in the construction industry and some primary and secondary schools. These programs can provide intervention at timely points and in accessible settings where other services or professionals may have limited opportunities to intervene.

Action Area 2 will be achieved through:

- adopting and promoting universal programs to support the acquisition of life skills that enhance individual and community resilience;

- adopting and promoting mental health and wellbeing programs for the whole community as well as high-risk groups;

- fostering environments (e.g. families, schools, workplaces) where the expression of emotions such as anxiety, stress, sadness and grief is met without fear or stigmatisation;

- adopting and promoting programs that raise awareness of mental disorders and the importance of wellbeing and suicide prevention;

- adopting and promoting programs to enhance help-seeking behaviour among high-risk groups and those who are least likely to seek help (e.g. young people, men, people from Aboriginal communities and people from culturally and linguistically diverse backgrounds); and

- work to destigmatise conditions that contribute to suicide risk (e.g. mental illness, homelessness, financial hardship) with a view to encouraging help-seeking behaviour.

Action Area 3. Improving community strength, resilience and capacity in suicide prevention

Research indicates that a sense of belonging is an important protective factor against suicide. Significant attention has been given to the idea of developing community networks, also referred to as community capacity building. Although there is broad support for community capacity building, the evidence base of successful practice in this area is currently under-developed.

Action Area 3 promotes strategies that engage with people who are neither professionals in suicide prevention nor part of a formally organised group. This includes family members, carers and peers who are often closest to someone at risk and are therefore a major asset in suicide prevention.

Action Area 3 will be achieved through:

- raising awareness of the characteristics of healthy and resilient communities and supporting their development;

- strengthening the capacity of families, schools, workplaces, religious groups and recreational and social groups to quickly identify and respond to indicators of potential suicidal behaviour;

- developing and disseminating resources that recognise and support the important role of family, friends, colleagues and peers in suicide prevention;

- educating communities to identify and respond to warning signs and risk factors for suicide;

- working with mainstream, community and multilingual media to raise awareness about suicide prevention and how to responsibly cover related issues;

- reducing the stigma and myths surrounding suicide by encouraging people to talk more openly about mental health problems and seek help early; and

- supporting local groups and agencies to work together to reduce individual and community risks, strengthen protective factors and respond to crisis situations or major changes (e.g. drought and industry closures).

Action Area 4. Taking a coordinated approach to suicide prevention

Effective suicide prevention depends on open communication, consistent collaboration and strategic coordination between communities, agencies and all levels of government.

In certain circumstances people at risk may be known to a number of different people, sectors and departments. This Action Area focuses on the role of key agencies, and addresses the broader issues that may hinder effective suicide prevention.

In regional areas, working relationships are embedded in key agencies such as education, health and police. However, significant improvements in care coordination are essential, particularly among Aboriginal communities, in order to heighten and enhance the efficacy of suicide prevention initiatives.

Action Area 4 will be achieved through:

- coordinating suicide prevention initiatives across local, state and Commonwealth governments and between government, non-government and private sectors;
- encouraging and resourcing integrated solutions to local suicide prevention needs;
- developing practical tools for information sharing, including shared service agreements;
- developing local data, outcome measures and joint service/client protocols;
- improving information sharing and reducing duplication of services between governments, academic institutions, non-government organisations, and peak and professional bodies;
- implementing a critical response model for communities experiencing early signs of crisis and the potential for an increase in suicide;
- developing cross-government mechanisms to improve the integration of health, housing, community, justice, employment and other policies and programs for suicide prevention;
- addressing the information and training needs of professional and community groups concerned with suicide prevention;
- actively engaging local government in suicide prevention; and
- strengthening local capacity by supporting the shared expertise of community and emergency services involved in suicide prevention.

Action Area 5. Providing targeted suicide prevention activities for high-risk groups

Comprehensive research data and analysis has improved the ways in which specific high-risk groups are identified and examined. However, further improvements are essential in specifically targeting high-risk groups.

Aboriginal people

The exceptional circumstances of Aboriginal people in Western Australia require a specific focus and attention.

Suicide can be seen as a direct result of the disadvantage faced by many Aboriginal people and is often exacerbated by broader underlying social, economic and health issues.

The breakdown of the family and the community, "skin" and kinship systems and Aboriginal law as well as entrenched poverty, continuing exposure to racism, alcohol and drug misuse and the effects of institutionalisation have profoundly disrupted and dislocated traditional Aboriginal ways of life. This situation has impacted on every dimension of Aboriginal life, including employment, housing, education and law and justice. In many Aboriginal communities there have been devastating intergenerational consequences on the mental health and wellbeing of children and young people. Furthermore, the development of functional Aboriginal male roles, the notion of status and individual and collective hopes for the future have been dramatically destabilised. [43]

Addressing the complex and problematic issue of suicide and deliberate self-harm in both metropolitan and rural Aboriginal communities is crucial. Aboriginal communities have identified the need for stronger relationships between mainstream and community-controlled services, improvements in sharing cultural and other expertise and the creation of culturally safe spaces within both sectors.

Given the national thrust towards improving the capacity of mainstream services to address Aboriginal peoples' needs, a key priority for the State Government is respectful collaboration between Aboriginal and non-Aboriginal service providers in the delivery of culturally secure services. Aboriginal suicide prevention demands policies and interventions that immediately respond to people in crisis and address longer-term social and community problems such as family violence and addiction.

Effective suicide prevention strategies for Aboriginal people must:
- be based on consultation;
- respect cultural beliefs and attitudes around suicide and mental health, and provide holistic, culturally secure responses; and
- ensure ownership and involvement by local community members.

Men

Contributing factors to male suicide include emotional, interpersonal and social components that result in isolation, desperation and a loss of hope and optimism. Research indicates that the lower rate of help-seeking among men is a significant issue[44] and is due to:

- low awareness of mental health issues and of available services;
- negative preconceptions of services; and
- concepts of masculinity that devalue help-seeking.

Programs aimed at encouraging help-seeking actions in men need to overcome powerful barriers that are deeply embedded in ideological notions of masculinity. Suicide prevention activities should support men to understand a number of key stressors and a range of emotions, including grief, anger and stress, as well as emphasising that asking for help from a professional or developing self-help skills is a courageous and acceptable means to solve problems. An understanding and knowledge of how men are socially and culturally positioned, can enhance men's independence, confidence, abilities and thereby improve their emotional health and wellbeing.

Youth

While youth suicide has generally declined in recent years, continued vigilance and attention is required in this area. Particular sub-groups, such as young males aged 15–24 years in rural and remote areas, have recorded increased rates of suicide over the same period. A combination of harsh economic circumstances, social isolation, a culture of stoicism, lower levels of access to services and higher access to lethal means present distinct challenges to suicide prevention efforts in that population. Raising awareness in rural and remote communities and encouraging a culture of appropriate help-seeking and mutual support is essential. However, improving access to sparse services and geographic isolation continues to present complex and ongoing challenges.

Intentional self-harm is a recognised risk factor for suicide, and while reports indicate that self-harming behaviours among school-age populations have increased, a significant number of people who self-harm go unnoticed by the health system. Therefore, enhancements in the integration between hospital-based services and community based supports are integral to improve this problem.

Migrants

The rates of suicide among migrant communities tends to reflect the rates of suicide in a person's country of origin rather than in the country of resettlement.

Community education and awareness programs need to be mindful of these different views regarding suicide and provide multifaceted strategies that are culturally and linguistically appropriate in communities or sub-groups with high-risk. Indeed, some cultures may view suicide as acceptable and preferable to losing face or honour, while other cultures may consider suicide as a grave sin that brings shame and disgrace to the family.

Clients discharged from mental health services

A significant number of people who suicide have experienced mental health problems and many of these have had contact with mental health services. A particularly high-risk time for suicide is after a person has been discharged from an inpatient mental health service. Therefore, careful discharge planning and continuity of care for people with mental health problems who are returning to the community is critical.

Correctional settings

Over the past five years, a significant body of research has been developed in relation to the Western Australian prison system. The suicide risk factors in relation to people in custody are well documented, with the risk of suicide elevated during the remand and post-release periods, at the loss of appeal and at the denial of parole period. As a result of these indicators, careful monitoring is needed across the corrective services system.

Child protection services

If a child experiences abuse and/or neglect, he or she is at an increased risk of suicide. The levels of self-harm are notably higher in this population and present significant challenges for the care and management of children and young people in child protection settings. The transition out of care and into adult life is often an extremely difficult time. Therefore consistent and ongoing support is central to establishing their emotional health and wellbeing.

Individuals and families bereaved by suicide

Intense feelings of grief and a sense of loss are the most common emotions felt by those bereaved by suicide. These feelings are often compounded by a sense of shame, guilt and the stigma associated with suicide. Appropriate and practical support services for the bereaved and training for health professionals who work in this area are essential in preventing further suicides, and form part of the postvention aspect of suicide prevention.

Same-sex attracted young people

Research indicates that same-sex attracted young people may be up to six times more likely to attempt suicide than the general population, with young people in rural areas particularly at risk. Higher rates of suicide are also associated with transgender youth.[45]

Action Area 5 will be achieved through:

- developing Community Action Plans for communities within communities such as an isolated Aboriginal community or an institution such as a prison;
- developing and promoting innovative programs and supports for high-risk populations who traditionally do not access health services;
- making services more accessible and culturally secure;
- developing support systems for people who have attempted suicide and for their families;
- improving supports for people with mental health problems or mental illness who are at risk of suicide;
- supporting interventions that target high-risk groups;
- implementing guidelines, training and supports for frontline workers who routinely interact with high-risk groups;
- providing education and information for consumers and carers to identify and respond to suicidal behaviour;
- improving the emotional health of women and their families during pregnancy and the first postpartum year;
- implementing awareness-raising strategies to combat bullying and homophobia in schools;
- developing and promoting confidential peer support opportunities;
- educating and informing professionals, service providers, families and community organisations in the provision of safe and secure care environments for people at risk; and
- providing access to training in suicide prevention.

Action Area 6. Implementing standards and quality measures in suicide prevention

The Strategy recognises the importance of evaluation as an essential component of implementation. Evaluation has several purposes in this context: it builds the evidence base to support planning; ensures that interventions align with best practice and have achieved their objectives; describes outcomes at individual and population levels; and demonstrates accountability of taxpayer funds.

The implementation of standards is also critical when developing suicide prevention policy and interventions as they support program development, help measure effectiveness and assist quality improvement.

Action Area 6 will be achieved through:

- developing and promoting standards for suicide prevention;
- developing and promoting systematic evaluation models;
- promoting evaluation and research which builds the evidence base of suicide prevention and enhances practice;
- identifying the skills and training required to work effectively in suicide prevention;
- developing and maintaining timely, robust and transparent reporting systems to ensure that information on suicide programs is readily available;
- increasing information sharing on suicide prevention initiatives, to reduce duplication and promote good practice; and
- promoting and providing funding arrangements to support community responses to emerging needs.

Everyone can help prevent suicide. It is people working together with a shared vision that will make the difference.

Appendices
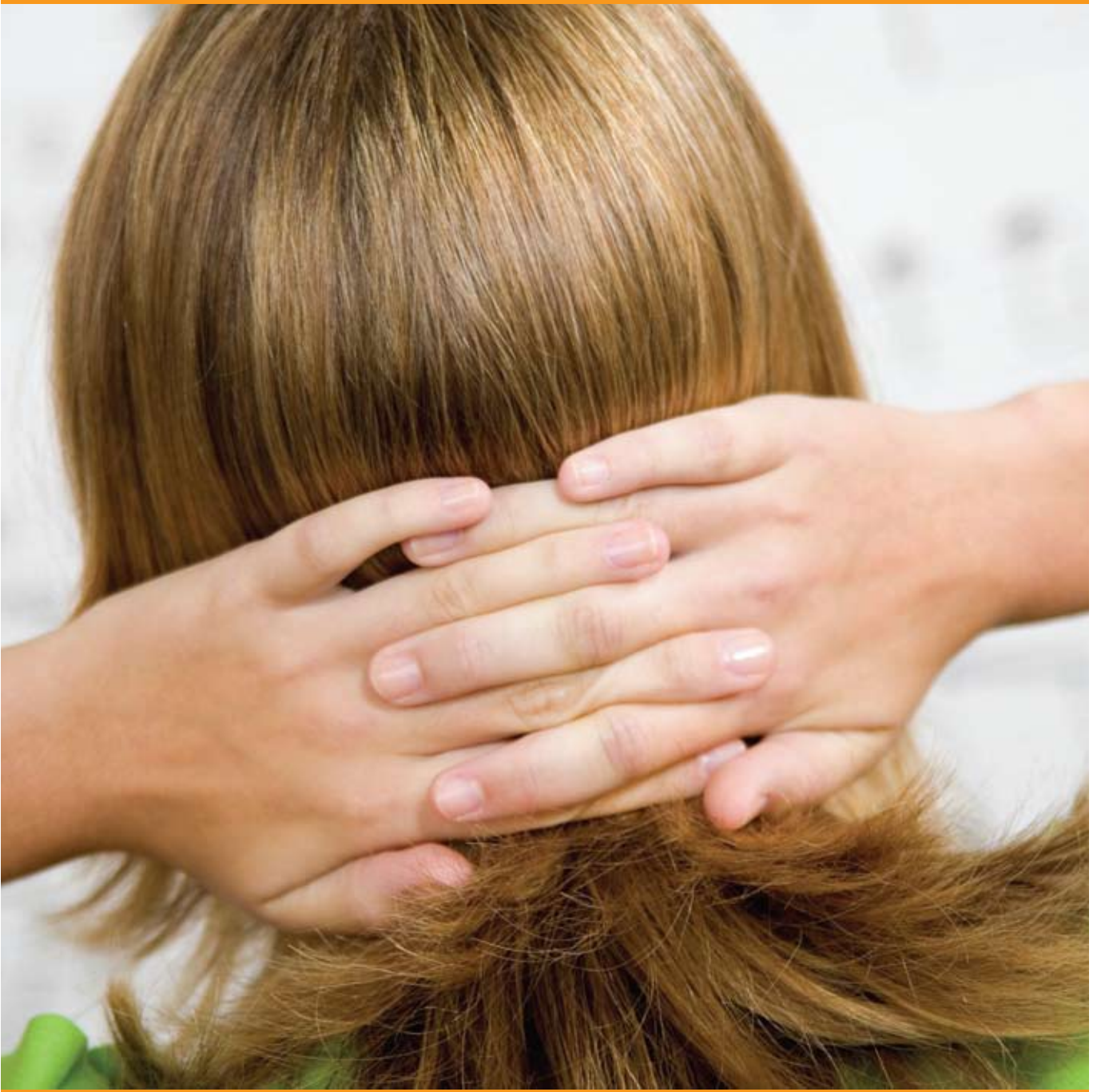
Appendix A – Western Australian Suicide Prevention Strategy Consultation

In partnership with the Department of Health's Mental Health Network, the Ministerial Council for Suicide Prevention organised a series of community forums across Western Australia. These forums were designed to obtain feedback and further input from consumers, carers, service providers and other stakeholders to support the planning process.

Summary of participants in consultation process by area 2007
(Available: http://www.mcsp.org.au/prevention/prevention_plan - 24 March 2009)

Albany

- Public Health
- Silver Chain
- Headspace
- WA Police
- Men's Resource Centre
- Great Southern Mental Health
- The Lighthouse
- City of Albany
- Youth City of Albany
- Manager Men's Resource Centre
- Great Southern Grammar School
- Great Southern Local Community Partnership
- Commonwealth Respite & Carelink Centre
- Great Southern General Practice Network
- Great Southern Anglicare
- Rural Financial Counselling Service WA
- Southern Agcare
- Housing Services Southern Region
- Department for Community Development
- Office for Children and Youth
- WA Department for Health and Aging
- Community Justice Services
- Non Government Schools Psychology Service
- Young House

Geraldton – 17 members not listed

Bunbury

- Aboriginal Health Council
- Agencies for South West Accommodation Inc: Reconnect
- Bunbury Mental Health
- Consumer Advisory Group
- Busselton Working Group
- Resilience Project
- Consumer Advisory Group
- City of Bunbury
- Community Safety & Crime
- Prevention Liaison
- Department of Education and Training
- Department for Communities
- Disability Services Commission
- Edith Cowan University Student Social Work
- Greater Bunbury Division of General Practice
- Injury Control Council WA
- Investing In Our Youth
- LAMP Inc
- Manjimup Collie Aboriginal Health Service/GP Downsouth
- Magumarri WA
- Mental Health Consumer
- Advocate
- Police (South West Crime Prevention)
- Regional Catholic Education Office.
- Northcliffe Family Centre
- Registered Nurse South West
- Relationships Australia – Bunbury
- Shire of Dardanup
- Strong Families – Department for Child Protection
- Support Officer – Edith Cowan University
- South West Aboriginal Medical Service
- South West Carelink & Carer Respite Centre
- South West Community Mental Health
- Val Lishman Foundation
- WA Count

Rockingham

- Adult Mental Health
- Care Options
- Rockingham Hospital Emergency Department
- City of Rockingham
- Eudoria St Centre
- Department for Child Protection
- District Office of Education
- Compassionate Friends
- Division of General Practice
- EIC
- Jacaranda House
- June O'Connor Centre
- Mandurah Community Drugs Service Team
- Meade Centre
- Mental Illness Fellowship Inc.
- Ministries for Communities
- Multicultural Centre. Fremantle
- Murdoch Counselling
- Rockingham Kwinana Adults Mental Health Services
- Rockingham Kwinana Child and Adolescent Mental Health Services
- Rockingham City Council
- Rockingham Juvenile Justice
- Rockingham Kwinana Mental Health
- Peel Rockingham Kwinana Mental Health
- Brightwater Care Group
- Ruah Community Services
- Rockingham Senior High School
- St John of God
- Station Co-ordinator Rockingham
- Streetnet
- Youth Focus
- Youth Services Rockingham

Karratha

- Department of Health
- Department of Education & Training
- Department of Corrective Services
- Perth Division of General Practice
- Shire of Roebourne
- Youth Involvement Council

North Metro

- Carer
- Centrecare Joondalup
- City of Wanneroo
- Community Member
- Department of Education & Training WA
- GROW
- ARAFMI
- Mental Health Division
- Mercy Reconnect
- Non Government Schools Psychology Service
- Perth & Hills Division of General Practice
- Reach Out
- South Metro Mental Health Service
- Youth Focus

Derbarl Yerrigan

- Yorgum
- Aboriginal Alcohol and Drug Service
- Youthlink
- South Metropolitan Public Health Unit

Northam

- Anglican Church
- Community Member
- Department of Health & Ageing
- Mental Health Network
- Mentally Healthy WA
- Northam Over 60's Group
- Northam Residential College
- Student Nurse
- WA Country Health Service – York District Hospital
- WA Country Health Service Wheatbelt
- Waminda House
- WA Police Service
- Wheatbelt Aboriginal Health Service
- Wheatbelt General Practice Network
- Wheatbelt PHU
- Wheatbelt Policy
- Department of Education & Training

- Wheatbelt Public Health Unit
- Wheatbelt Resilience
- WMB – Safer Northam
- WMHA
- Wheatbelt Coordinated Response to Family and Domestic Violence Committee
- WSS

Metro Central

- Cambridge Youth Service
- Canning Community Education Centre Support
- City of Cockburn
- City of Fremantle
- Communicare Inc
- Department for Child Protection
- Joondalup Community Mental Health
- Lifeline
- Men's Advisory Network
- Mental Health Division
- Office for Children and Youth
- Office for Seniors Interests
- Royal Perth Hospital – Emergency Department Mental Health
- Salvation Army
- Child Death Review Committee
- Shire of Kalamunda
- South metropolitan CAMHS
- St John of God Health Care
- UWA Student Council
- WA AIDS Council
- Youth Reach South

Derbarl Yerrigan

- Aboriginal Alcohol & Drug Service
- City of Melville
- Department for Child Protection Aboriginal Support Worker
- Derbarl Yerrigan Health Service
- DHYS
- Outcare Inc.
- Yorgum – Building Solid families
- Kalgoorlie
- Community Mental Health Service
- Community Member

- Community Mental Health
- CRS Australia
- Department of Indigenous Affairs
- Department for Education &Training
- Eastern Goldfield Sexual Assault Referral Centre
- FACommunity Services Indigenous Affairs
- General Practice Network
- Goldfields Drug Service Team
- Goldfields Suicide Prevention
- Goldfields Woman's Health Care Centre
- Investing in Our Community
- KAAP
- Kalgoorlie Hospital Aged Care Unit
- Mental Health Support
- Mission Australia
- WA Country Health Service

Broome

- Broome Region Aboriginal Medical Service
- Centrelink
- Kimberly Aboriginal Medical Service
- Shire of Broome
- Regional Centre for Social and
- Emotional Centre
- Kimberley Adult Mental Health Service – live life, stay solid
- Kimberley Population Health Unit
- WA Police
- Kinway
- Department of Indigenous Affairs
- Kimberley Mental Health
- Burdekin Youth in Action
- Men's Outreach Service
- Kimberley Development Commission
- Kimberley Community Drug Service Team

Derby

- Social, Emotional Wellbeing

To date, national projects funded under the National Suicide Prevention Strategy have included both population-based and community-based approaches to suicide prevention at the local level. During 2008-09, the Department of Health and Ageing will ensure that both streams better complement and enhance each other to reach high-risk individuals, groups and the geographic areas in need.

To enable this, the National Suicide Prevention Strategy will focus its activities in 2008–09 on:

1. Augmenting existing population-based approaches by focusing on specific target groups and regions with an increased or systemic prevalence of suicide risk factors.
2. Strengthening local activities by emphasising coordination and better use of existing resources, services and organisational capacity.

A national demonstration project launched in June 2008 and developed in close consultation with state and territory mental health departments will provide additional Access to Allied Psychological Services (ATAPS) support for patients at risk of suicide and self-harm. The project is currently being implemented in 15 Divisions of General Practice, including the Divisions of Rockingham and Canning with further divisions currently under review.

The Commonwealth Government is providing $20.6 million to the National Suicide Prevention Strategy in 2008–09 to implement these activities. The Commonwealth Government will continue to work closely with states and territories on the strategic coordination of the National Suicide Prevention Strategy.

National projects include projects which focus on mental health promotion, prevention and early intervention initiatives in Australian primary and secondary schools, pre-service secondary school teachers, Mental Health First Aid with adolescents, apprentices within the construction industry, crisis support through call-back service and bereavement support group standards and practice.

A variety of community-based projects have been funded in each state and territory including Western Australia in 2008–09. These projects contribute to outcomes specified in the National Suicide Prevention Strategy: *Living is for Everyone* (LIFE) and support high-risk groups including Aboriginal and Torres Strait Islander communities, people bereaved by suicide, men (particularly in rural and remote settings) and rural and remote communities.

The formation and membership of the new Australian Suicide Prevention Advisory Council was announced on 12 September 2008. The Australian Suicide Prevention Advisory Council will provide advice on strategic directions and priorities to support the implementation of the National Suicide Prevention Strategy. Its members are working collaboratively both to identify priorities for the 2009–10 National Suicide Prevention Strategy Workplan and to provide the Minister for Health and Ageing with advice regarding objectives beyond June 2009.

References

1. Berndt C, Berndt R. The Aboriginal Australians: the first pioneers 2nd ed. Victoria: Pitman;1983.

2. Commonwealth Department of Health and Aged Care, (2000) LIFE (Living is for Everyone): A framework for prevention of suicide and self-harm in Australia—areas for action. Commonwealth Department of Health and Aged Care, Canberra,

3. Ministerial Council for Suicide Prevention. History of Ministerial Council for Suicide Prevention [Internet]. 2009 [cited 2009 June 8]. Available from: http://www.mcsp.org.au/abouthistory

4. Ministerial Council for Suicide Prevention, Report on Consultation Process September 2007 [Internet]. 2007 [cited 2009 June 8]. Available from http://www.mcsp.org.au/files/user4/MCSP.pdf

5. World Health Organisation: Department of Measurement and Health Information 2004 [Internet].2004 [cited 2009 June 8], Available from: http://www.who.int/healthinfo/statistics/bodgbddeathdalyestimates.xls

6. Commonwealth Department of Health and Aged Care, (2000) LIFE (Living is for Everyone): A framework for prevention of suicide and self-harm in Australia—areas for action. Commonwealth Department of Health and Aged Care, Canberra.

7. Commonwealth of Australia (2008), 3303.0 Causes of Death, Australia, 2006 Australian Bureau of Statistics, Canberra

8. Ibid.

9. Peck, D. Warner, K. (1995) Accident or Suicide? Single-vehicle car accidents and the intent hypothesis. Adolescence Journal Summer Edition.

10. Telethon Institute for Child Health Research, WA Coroner's Database on Suicide, 2009 unpublished data.

11. Ibid.

12. Ibid.

13. Miller, KM., Freemantle, J., Silburn, S., Sayers MR., Phillips, S. (2004). Help-seeking behaviours of suicidal men aged 17-35 years in the Perth Metropolitan Area: Final report. Perth, Western Australia [internet] (cited 15/06/09) available at http://www.mcsp.org.au/resources/publications

14. Telethon Institute for Child Health Research, WA Coroner's Database on Suicide, 2009 unpublished data.

15. Hunter E, Reser J, Baird M, Reser P. (1999) An analysis of suicide in Aboriginal communities of north Queensland: the historical, cultural and symbolic landscape. University of Queensland, Gurriny Yealamucka Health Service and the Yarrabah Community Council. Canberra: James Cook University of North Queensland

16. Royal Commission into Aboriginal Deaths in Custody (1991) National Report (Commissioner Elliott Johnston), 5 volumes, AGPS, Canberra, 1991

17. Telethon Institute for Child Health Research, WA Coroner's Database on Suicide, 2009 unpublished data

18. Ibid

19. Kyrios M. (1994) Suicidality, culture and migrants. In suicide crisis in community and rural health. Lifeline Ballarat, pp 57-80

20. Commonwealth Department of Health and Aged Care, LIFE (Living is for Everyone): Research and evidence in prevention Commonwealth Department of Health and Aged Care, Canberra; 2000.

21. Ibid.

22. McDonald R, Steel Z. Immigrants and mental health: An Epidemiological perspective. Transcultural Mental Health Centre, Sydney; 1997.

23. Commonwealth Department of Health and Aged Care, op cit;; Loue, S. & Quill, B. E. (2001), Handbook on rural health, Kluwer Academic/Plenum Publishers, New York; 2000.

24. Hassan R. Social factors in suicide in Australia. Australian Institute of Criminology; Canberra: 1996 6p Trends and Issues in Criminal Justice 52; 1995.

25. Blaauw E, Kerkhof J. Screening prisoners for suicide risk. In G.E. Dear (Ed.), Preventing suicide and other self-harm in prison (pp 41-52). New York: Palgrave Macmillan; 2006.

26. Sankey M. Suicide and risk-taking deaths of children and young people. NSW Commission for Children and Young People. Sydney: NSW Centre for Mental Health; 2003.

27. Beautrais, A. 'Child and young adolescent suicide in New Zealand', Australian & New Zealand Journal of Psychiatry, vol. 35, pp. 647-653; 2001.

28. SANE Australia, http://www.sane.org/action/action/suicide_prevention.html, accessed 9 July 2009

29. Dyson S, Mitchell A, Smith A, Dowsett G, Pitts M and Hillier L. Don't Ask, Don't Tell, Hidden in the crowd: The Need for Documenting Links between Sexuality and Suicidal Behaviours Among Young People, Monograph Series No.45, The Australian Research Centre in Sex, Health and Society, La Trobe University, Melbourne; 2003.

30. Ibid

31. Telethon Institute for Child Health Research, WA Coroner's Database on Suicide, 2009 unpublished data

32. Ibid

33. Oates, M. Perinatal psychiatric disorders: a leading cause of maternal morbidity and mortality. Br Med Bull; 67: 219-29; 2003.

34. Australian Bureau of Statistics. Mental health and wellbeing: profile of adults, Western Australia Canberra: ABS; 1997-98. ABS publication 4326-5.

35. Commonwealth of Australia, Commonwealth Department of Health and Aged Care, National Youth Suicide Prevention Strategy. Setting the evidence-based research agenda for Australia: A literature review, Commonwealth of Australia, Canberra; 1999.

36. Serafino S, Somerford P, Codde J. Hospitalisation as a consequence of deliberate self-harm in Western Australia, 1981-1998, Health Department of Western Australia, Perth; 2000.

37. Telethon Institute for Child Health Research, WA Coroner's Database on Suicide, 2009 unpublished data

38. Ibid.

39. Commonwealth Department of Health and Aged Care. LIFE (Living is for Everyone): A framework for prevention of suicide and self-harm in Australia—areas for action. Commonwealth Department of Health and Aged Care, Canberra; 2000.

40. Ibid.

41. Mrazek P. and Haggerty R. (1994). Reducing risks for mental disorders: frontiers for preventative intervention research, Committee on Prevention of Mental Disorders, Division of Biobehaviorial Sciences and Mental Disorders, Institute of Medicine, Washington, National Academy Press.

42. Ibid.

43. Silburn S, Zubrick S, De Maio J, Shepherd C, Griffin J, Mitrou F, Dalby R, Hayward C, Perason G. The Western Australian Aboriginal Child Health Survey: Strengthening the Capacity for Aboriginal Children, Families and Communities, Curtin University of Technology and Telethon Institute for Child Health Research, Perth; 2006.

44. Sayers M, Miller K. Help-seeking behaviours of suicidal men aged 17-35 years: a consumer consultation and participation pilot project. Ministerial Council for Suicide Prevention, Perth; 2004.

45. Dyson S, Mitchell A, Smith A, Dowsett G, Pitts M and Hillier L. Don't Ask, Don't Tell, Hidden in the crowd: The Need for Documenting Links between Sexuality and Suicidal Behaviours Among Young People, Monograph Series No.45, The Australian Research Centre in Sex, Health and Society, La Trobe University, Melbourne; 2003.

Delivering a **Healthy WA**

This document can be made available in alternative
formats such as audio tape, computer disc or Braille,
on request from a person with a disability.