**Australian Government**

**Australian Institute of Family Studies**

# Australian Senate Community Affairs Reference Committee

# Inquiry into Suicide in Australia

## Submission from the Australian Institute of Family Studies

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The Australian Institute of Family Studies (the Institute) is pleased to have the opportunity to make a submission to the Australian Senate Community Affairs Reference Committee's Inquiry into Suicide in Australia. The Institute's submission has focused on the following four Terms of Reference for the Inquiry:

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

c) the appropriate role and effectiveness of agencies, such as police, emergency departments, law enforcement and general health services in assisting people at risk of suicide;

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

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

This submissions draws upon research that the Institute has conducted on a range of matters relating to suicide. This includes an evaluation of the National Youth Suicide Prevention Strategy (completed in 1999), research related to the impact of suicide on families and suicide postvention[1] and suicide and mental health issues.

## *Suicide in Australia*

Suicide is a significant social and public health problem in Australia. Over 2.1 million Australians aged 16-85 years have, at some point in their lifetime, had serious thoughts about taking their own life. Over 500,000 have attempted suicide (Slade, Johnston, Teesson, Whiteford, Burgess, Pirkis & Saw, 2009). There were 1,881 deaths registered as suicide in 2007 (Australian Bureau of Statistics [ABS], 2009).

While suicide accounts for only about two percent of all adult deaths in Australia, it is estimated to be responsible for 10.6 percent of years of life lost through premature death in 1998 (ABS, 2003). Suicide is the second highest contributor to deaths in the 12–24 year old age group (accounting for 19% of deaths in 2004), although youth suicide rates have fallen in recent years, especially for young men where the rate is now about half of the peak reached in 1997 (AIHW, 2007).

[1] The term 'postvention' indicates activities that assist those bereaved by suicide to cope with what has occurred.

# Terms of Reference A. *Personal, social and financial costs of suicide in Australia*

The Institute has undertaken research related to post-suicide outcomes for families and strategies for support and counselling the suicide bereaved (Flynn & Robinson, 2008). While it is difficult to quantify the number of people who are bereaved by suicides, the generally accepted estimate is that, on average, there are six suicide bereaved for each suicide (Beautrais, 2004). Using this estimate of the number of bereaved for each suicide and the fact that the number of apparent deaths by suicide remained consistent at around 2,000 in the ten years to 2007 (ABS, 2009), we estimate that approximately 120,000 Australians have been bereaved by suicide in the past decade.

There is evidence that suicide bereavement is different from bereavement associated with other forms of death. Suicide-bereaved people tend to have more difficulties understanding the meaning of the death, and can experience guilt and blame (from self and others) for not preventing the death, feelings of rejection (Clark & Goldney, 2000), isolation and abandonment, anger towards the deceased (Jordan, 2001), complicated grief[2] (Provini, Everett & Pfeffer, 2000) and slower recovery (Beautrais, 2004). A less severe grief reaction may be felt in situations when the deceased had a long history of severe physical or mental health problems, including previous suicide attempts (Beautrais, 2004), and the death may not necessarily be unexpected (Jordan, 2001). Bereavement is also influenced by factors such as the age of the deceased, the quality of the relationship between the deceased person and the bereaved person, and cultural beliefs (Hawton & Simkin, 2003).

Suicide-bereaved individuals also report feelings of stigma (Beautrais, 2004; Harwood et al., 2002), rejection, isolation, lack of social support and blaming by family members and community (Clark & Goldney, 2000; Jordan, 2001). These factors have the potential to impact on the likelihood of suicide-bereaved people seeking appropriate professional help when needed.

# Terms of Reference *C. The appropriate role and effectiveness of agencies in assisting people at risk of suicide*

It is extremely difficult to predict who will choose to end their own life. This is because some risk factors for suicide are more important for some groups than others, similar life events can have different impacts, and people vary in their opinions on what is worth living for (Department of Health and Ageing, 2007). The Living is for Everyone (LIFE) Framework (Department of Health and Ageing, 2007) outlines a number of overlapping domains of care and support in its suicide prevention model to address the problem of identification of people likely to take their own life. These range from universal intervention approaches that engage whole populations, through to more targeted support for vulnerable groups. Agencies adopt many different approaches to addressing the issue of suicide in their communities.

[2] Complicated grief is more complex and enduring than "normal" grief, and is associated with lasting mental health problems (e.g. major depression and substance abuse), decreased social functioning and physical illness (Vessier-Batchen & Douglas, 2006).

*Mental illness*

There is a strong link between mental illness and suicidal behaviour[3]. According to data from the 2007 National Survey of Mental Health and Wellbeing, almost one in ten people with mental disorders reported being suicidal in the previous twelve months (Slade et al, 2009). Those who have received inpatient care for mental illness, and following discharge from psychiatric care or emergency departments, are at particularly high risk (Department of Health and Ageing, 2007). Suicidal behaviour is one of the most extreme manifestations of mental illness, although it is important to note that not everyone who suicides had a mental illness, and nor do all people who have a mental illness engage in suicidal behaviour (Department of Health and Ageing, 2007).

Focusing on mental health problems in the context of family relationships is an important component of a community-wide response to mental illness, with some indication that interventions at a household level can be a key strategy to address mental health problems (Butterworth, Rodgers, & Jorm, 2006). Family relationship services are in a key position to screen for, identify and deal with mental health problems as they become evident in the therapeutic process (Robinson, Rodgers & Butterworth, 2008). Family relationship services are able to not only address the impact of mental health problems on couple and family relationships, but also the impact of these family relationships on mental health.

It is important for family relationship organisations to have a written plan of action for dealing with screening and assessment for suicide risk and to respond to varying levels of need (e.g. referring to emergency services or crisis mental health services) (Robinson, Rodgers & Butterworth, 2008). Members of staff need to be familiar with the recommended procedures, and may need training in responding to suicidal people. A plan for assessing and managing distressed clients on the telephone may also be appropriate in order to manage concerns for client safety.

*Suicide bereaved*

An important element of postvention work relates to the elevated risk of suicidality associated with suicide bereavement and the need for "proactive monitoring of the risk for psychiatric disorder and suicidality" amongst the suicide bereaved (Jordan, 2001). Given the increased risk of additional suicides, the damaging consequences on communication and development within the family and the particular difficulties children face, the facilitation of effective and appropriate family functioning is crucial (Jordan, 2001).

Lack of information about available services, shock, exhaustion or a loss of confidence in reaching out for help may reduce the amount of support received by the suicide bereaved (Wilson & Clark, 2005). One of the more effective ways of responding to the suicide-bereaved is to provide information and education about grief, bereavement, and suicide bereavement in particular, as part of the counselling process. Dunne (1992) suggested that a psychoeducational or educational approach is helpful, particularly initially. While this may appear to be a simplistic strategy, it serves a critical role in helping the bereaved understand themselves and their responses. The level of disruption to many aspects of life and functioning, and the debilitating effect of the trauma and grief, will be beyond what most people have experienced in their lives. Many bereaved persons express fear and concern about how they are coping in terms of emotions, thinking and behaviour, and may, for example, wonder if they are going mad or if the grief is taking too long.

[3] Suicidal behaviour is defined here as including a wide variety of behaviours, from suicidal thoughts and gestures through to self-harm, attempted suicide and completed suicide.

Grief following suicide has many features commonly associated with trauma and post-traumatic stress (Barlow & Morrison, 2002). Educational and informational approaches providing knowledge about the typical responses to suicide, and what is known about strategies for coping can have a powerful, healing and normalising effect.

An example of this educational approach has been developed by the *Support After Suicide* project at Jesuit Social Services, Melbourne. During the course of an eight-week support group, an additional session is scheduled in which group participants invite friends and family to attend. This is an education session that provides information about suicide, the unique issues and experiences of the bereaved following suicide, and how to care for and support the bereaved. Another example is the range of Information Sheets developed by the *Support After Suicide* team, with themes such as "Grief and suicide" and "Understanding suicide" (see: http://www.supportaftersuicide.org.au/home/).

## Terms of Reference *F. The role of targeted programs and services that address the particular circumstances of high-risk groups*

One approach to suicide prevention is to target people who have known risk factors for suicide. This section draws upon work conducted by the Australian Institute of Family Studies which examine responses to suicide that are relevant to three at-risk groups: young people; the suicide bereaved; and men.

*Young people*

The Australian Insitute of Family Studies conducted the evaluation of the National Youth Suicide Prevention Strategy (the Strategy), which operated from 1995-1999 (Mitchell, 2000).

The goals of the Strategy were to:

- prevent premature death from suicide among young people;
- reduce rates of injury and self-harm;
- reduce the incidence and prevalence of suicidal ideation and behaviour; and
- enhance resilience, resourcefulness, respect and interconnectedness for young people, their families and communities.

The evaluation showed that the Strategy did initiate many activities that were appropriate to the achievement of its stated goals. Furthermore, the range of Strategy activities addressed nearly all of the prevention approaches identified as necessary in the research literature. A number of projects under the Strategy demonstrated positive outcomes for young people, and there was evidence that there was a markedly higher level of awareness of youth suicide issues throughout service systems.

Five major themes emerged concerning principles of good practice in the prevention of youth suicide:

- **Multidimensional approach**, including attention to: the full spectrum of interventions; whole populations as well as high risk sub-populations and individuals; a range of different settings and sectors; multiple levels of action including target populations, service agencies, service systems and all levels of Government.

- **Access,** including: universal and selective targeting; flexible selection criteria and sources of referral; delivery in multiple community-based settings; having multiple 'soft' entry points.
- **Engagement,** including: service providers developing a better knowledge of adolescent health issues and skills in challenging negative assumptions about young people's culture; providing a relaxed youth-friendly environment and holistic service in one location; assertive follow-up.
- **Effective intervention,** including: the importance of services actively engaging in an ongoing process of generating, reflecting and acting on evidence about the effectiveness of their own daily practice; interventions that address protective factors as well as risk factors; providing adequately holistic interventions (which proved difficult in practice but nevertheless was considered vitally important).
- **Capacity building,** including: genuine collaboration between organisations to develop and work towards shared goals; increasing the capacity of organisations who operate with severe resource limitations and competing priorities for service reform.

Two strategies were suggested that would progress these aims:

- Development of learning organisations, to enhance the accessibility and effective use of practice-based evidence.
- Systematic policy frameworks, so that local partnerships are complemented and supported by strategic partnerships between: Commonwealth Government departments; the Commonwealth and State/Territory departments; and State/Territory departments and area/regional/district authorities.

The current National Suicide Prevention Strategy (NSPS) builds on the work of the former National Youth Suicide Prevention Strategy, as described above. The work plan for the NSPS for 2008-2009 was characterised by a series of shifts in an approach to suicide prevention.[4] This included addressing the issues of strategic partnerships, with a collaborative and planned approach through partnerships with state/territory governments and community organisations for community-based suicide prevention initiatives. Other approaches within the work plan emphasise a focus on particular groups at risk of suicide, including individuals with prior attempts, those who live in rural and remote areas, people bereaved by suicide, Indigenous Australians, people with a mental illness, young people and men.

*Suicide bereaved*

There is evidence that greater attention could be given to postvention activities as a method of targeting at-risk groups for suicidal behaviour (Flynn & Robinson, 2008). Postvention work aims to help the suicide-bereaved live longer, more productively and less stressfully that they would likely do otherwise. Postvention also encourages healing within a community affected by a suicide and lessens the risk of suicide contagion (Laux, 2002).

Suicide-bereaved family members may be at a heightened risk for premature death, including suicide, yet the reasons for this remain unclear (Ness & Pfeffer, 1990). Clark and Goldney (2000) described those bereaved by suicide as an at-risk group, not necessarily due to the mode of death, but because "suicide identifies the vulnerable" (p. 470). Wilson and Clark (2005) described this as the high prevalence of risk

[4] http://www.health.gov.au/internet/mentalhealth/publishing.nsf/content/national-suicide-prevention-strategy-1

factors, rather than the mode of death itself, accounting for increased risks of depression and suicide in those who are suicide-bereaved.

A qualitative study of suicide-bereaved individuals (Wilson & Clark 2005) found that second- and third-degree relatives and non-relatives of the person who died by suicide often had great difficulty finding support for themselves and information on helping others. One respondent indicated that there was no information on "how to be a friend" (p. 116) or what to expect. The report encourages services to offer specific assistance and advice that will help relevant individuals, in turn, offer support, which may reduce the social stigma and blaming that some suicide-bereaved individuals report (Clark & Goldney, 2000; Jordan, 2001).

*Men*

Males are 3-4 times more likely than females to die by suicide (ABS, 2007; Slade et al, 2009). A recent paper published by the Australian Institute of Family Studies provides an overview of the evidence that shows men are less willing to seek help in times of crises, and that even if men are willing to seek help, they might not know where to receive it (Robinson & Parker, 2008). Men feel that services are focused on women and children, and this may extend to a belief that providers are biased towards delivering services that exclude them (Colmar Brunton Social Research, 2004). Issues such as the skills of service providers in working with men (Smith, Braunack-Mayer, & Wittert, 2006) and the nature and extent of the presenting problem (Galdas, Cheater, & Marshall, 2005), need further consideration.

The impact of stigma related to mental health issues has been found in some studies to be particularly strong for men in rural areas, for whom the pressure to be stoic in the face of adversity is considerable (Judd, Jackson, Komiti et al., 2006). Stoicism is seen as an important concept that regulates access to help in rural areas, and is considered by Judd, Jackson, Komiti et al. (2006) to be deserving of more research attention. In the case of farmers, stoicism may arise from a crucial imperative to fulfil the farming role, as the number of workers on a farm is often small, and time off for illness would have a significant impact on productivity. As such, men perceive taking practical steps, remaining optimistic and getting on with the job as the most useful strategies to deal with problems (Judd, Jackson, Fraser et al., 2006). As the rate of suicide in rural and remote areas of Australia is higher than for metropolitan areas (ABS, 2000), attention to issues that prohibit men from seeking more formal help in times of need is required.

## Terms of Reference G. *The adequacy of the current program of research into suicide and suicide prevention and the manner in which findings are disseminated*

There are considerable gaps in research into suicide, a few of which are outlined below:

*Postvention in Indigenous communities*

Few studies exist that have examined different cultural responses to suicide. In particular, while the rate of suicide of Indigenous Australians is estimated to be two to three times higher than that of non-Indigenous Australians (Tatz, 2001), suicide postvention programs have been limited (Elliott-Farrelly, 2005). This is of concern, given the frequent witnessing of suicides, commonality of clusters of suicide, and the ongoing grief felt by many in affected communities (Elliott-Farrelly, 2004). Tatz (2001) expressed the need for a

separate Aboriginal suicidology that addresses the differences in understanding of and responses to suicide in Aboriginal communities, compared to non-Indigenous communities. This could subsequently be used to better inform research, development and direction of future suicide initiatives (Elliott-Farrelly, 2004).

*Suicide-bereavement*

Further research is needed to focus on the qualitative aspects that differentiate suicide bereavement from other forms of bereavement, and effective responses to different target groups (Flynn & Robinson, 2008). An important aspect of this is addressing the stigma that still surrounds the act of suicide, so that those most affected are better protected from the fallout that surrounds such a traumatic event.

*Suicide-bereaved children*

There has been a limited amount written about the effects of parental suicide on children and adolescents, including bereavement responses through to adulthood, and existing results are inconsistent (Flynn and Robinson, 2008). Further research in this area is needed to consider the links between parental suicide and bereavement outcomes, and in comparison to other forms of parental mortality.

## Conclusion

In this submission, we have drawn attention to publications and research data held at the Institute that examines the impact of suicide, particularly on family and family members. Although identifying those who choose to take their own life is extremely difficult, the reasons for trying to prevent suicide are not only important in terms of loss of life, but also due to the impact on family, friends and communities more broadly. This submission highlights the needs of suicide-bereaved people, including recognition of their heightened risk for suicidal behaviours. Issues related to young people, men and Indigenous communities are also addressed. In particular, the evaluation conducted by the Australian Institute of Family Studies of the National Youth Suicide Prevention Strategy showed that many activities can effectively prevent suicide in young people. Further research on suicide and suicidal behaviours is needed, not only to assist in deciphering issues for those at risk, but also to clarify factors that promote resilience.

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## *Additional Resources*

### *Australian*

**Australian Institute for Suicide Research and Prevention**
The Australian Institute for Suicide Research and Prevention at Griffith University is at the forefront of national and international suicide research.
http://www.griffith.edu.au/health/australian-institute-suicide-research-prevention

**Living Is For Everyone (LIFE)**
The Living Is For Everyone website is a world-class suicide and self-harm prevention resource.
http://www.livingisforeveryone.com.au/

**HealthInsite**
This Australian Government internet gateway provides access to a wide range of up-to-date and reliable information on health and wellbeing including suicide.
http://www.healthinsite.gov.au/topics/Support_for_People_Affected_by_Suicide

**Ministerial Council for Suicide Prevention (WA)**
This website seeks to increase the access to and availability of suicide prevention information for professionals, researchers and community members.
http://www.mcsp.org.au/

**Suicide Prevention Australia**
Suicide Prevention Australia is a non-profit, non-government organisation working as a public health advocate in suicide prevention.
http://suicidepreventionaust.org/Home.aspx

**Support After Suicide**
Support After Suicide is a program of Jesuit Social Services and is funded by the Department of Health and Ageing under the National Suicide Prevention Strategy.
http://www.supportaftersuicide.org.au/home/

**ACROSSnet (Australians Creating Rural Online Support Systems)**
The ACROSSnet website aims to help members of rural and remote communities to access information, education and support regarding suicide and its prevention.
http://www.acrossnet.net.au/

**SANE Australia**
SANE Australia is a national charity working for people affected by mental illness through campaigning, education and research.
http://www.sane.org/index.php?option=com_content&task=view&id=444&Itemid=

**StandBy (Suicide Bereavement) Response Service**
StandBy Response Service is a coordinated community crisis response service for families, friends and associates who have been bereaved through suicide
https://www.supportlink.com.au/standby/index.htm

***International***

**University of Oxford Centre for Suicide Research**
The Centre for Suicide Research aims to increase knowledge directly relevant to prevention of suicide and deliberate self-harm.
http://cebmh.warne.ox.ac.uk/csr/

**Suicide Awareness Voices of Education (USA)**
SAVE is a USA-based not-for-profit organisation dedicated to the prevention of suicide through education.
http://www.save.org/

**American Association of Suicidology (AAS)**
AAS is a leader in the advancement of scientific and programmatic efforts in suicide prevention through research, education and training, the development of standards and resources, and survivor support services.
http://www.suicidology.org/web/guest/home

**National Suicide Research Foundation Ireland**
The NSRF is a centre of excellence contributing to the prevention of suicidal behaviour in Ireland.
http://www.nsrf.ie/

**International Association for Suicide Prevention (USA)**
This association is dedicated to preventing suicidal behaviour, to alleviate its effects, and to provide a forum for academians, mental health professionals, crisis workers, volunteers and suicide survivors.
http://www.iasp.info/resources/Suicide_Research_and_Prevention/

**National Institute of Mental Health (USA)**
The Institute aims to transform the understanding and treatment of mental illnesses through basic and clinical research, paving the way for prevention, recovery and cure.
http://www.nimh.nih.gov/health/topics/suicide-prevention/index.shtml

**Choose Life (Scotland)**
Choose Life is a ten-year Scottish Government plan aimed at reducing suicides in Scotland by 20% by 2013.
http://www.chooselife.net/home/Home.asp

**Ministry of Health (NZ)**
The Ministry of Health is the key government agency responsible for leading and coordinating the implementation of the New Zealand Suicide Prevention Strategy 2006-2016.
http://www.moh.govt.nz/suicideprevention

**Suicide Prevention Information New Zealand**
SPINZ is a national information service. Its main role is to provide high quality information to promote safe and effective suicide prevention activities.

http://www.spinz.org.nz

**Centre for Suicide Prevention (UK)**
The Centre for Suicide Prevention at The University of Manchester brings together a number of projects that aim to inform future policy and service planning. It is one of the United Kingdom's foremost research centres in the field of suicidal behaviour.
http://www.medicine.manchester.ac.uk/psychiatry/research/suicide/prevention/

**Centre for Suicide Prevention (Canada)**
The Centre for Suicide Prevention (CSP) is an education centre specializing in curriculum development; training programs; library and information services.
http://www.suicideinfo.ca/

**American Foundation for Suicide Prevention**
The Foundation is a leading national not-for-profit organization dedicated to understanding and preventing suicide through research, education and advocacy, and to reaching out to people with mental disorders and those impacted by suicide.
http://www.afsp.org/

**Suicide Prevention Action Network (SPAN) USA**
SPAN USA serves as the public policy and advocacy division of the American Foundation for Suicide (see above).
http://www.spanusa.org/

**National Office for Suicide Prevention (Ireland)**
The National Office for Suicide Prevention supports research in the areas of suicide research/prevention and mental health promotion.
http://www.nosp.ie/html/research.html

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