Suicide Prevention Australia
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16th May 2005

The Committee Secretary
Senate Select Committee on Mental Health
Department of the Senate
Parliament House
Canberra ACT 2600
Australia

Dear Sir/Madam

Please find attached a submission to the Senate Select Committee on Mental Health.

Yours sincerely

Dr Michael Dudley
Chair
Suicide Prevention Australia

**SUICIDE PREVENTION AUSTRALIA (SPA):**
**SUBMISSION TO SENATE SELECT COMMITTEE ON MENTAL HEALTH**

## Introduction

Suicide Prevention Australia (SPA) welcomes the opportunity to respond to the call for submissions to the Senate Select Committee on Mental Health.

The following submission to the inquiry reflects existing SPA policy and recommendations developed at the SPA 11th National Conference. This conference took the form of an extended conversation between researchers and practitioners, and was held from 30th-31st October 2004 in Sydney, at the University of New South Wales. Its aims were to emphasise evidence-based practice and practice-based research and evaluation, linking research to practice. During the conference, presenters were asked to indicate their recommendations for suicide prevention, with particular reference to the areas that they addressed. Contributors to the recommendations are listed in the appendix (it should not be necessarily assumed, however, that they would concur with all aspects of this submission).

The SPA conference recommendations have been organised as a commentary on the National Suicide Prevention Strategy, and its key document, *Living is for Everyone* (LIFE): *A framework for the prevention of suicide and self-harm in Australia (2000).* The National Advisory Council on Youth Suicide Prevention (NACSP) developed LIFE to inform workers and planners across all sectors of national priorities and directions in suicide prevention, and to broaden thinking across all sectors to incorporate a suicide prevention focus. In this submission document, SPA's recommendations have been re-worked to address the Senate Committee's terms of reference. Our responses are grouped under particular Terms of Reference (TOR's), and sometimes overlap with others (where this is the case, this is indicated).

The LIFE framework has six areas for action:

1) Promoting well-being, resilience and community capacity across Australia;
2) Enhancing protective factors and reducing risk factors for suicide and self-harm across the Australian community;
3) Services and support within the community for groups at increased risk;
4) Services for individuals at high risk;
5) Partnerships with Aboriginal and Torres Strait Islander peoples;
6) Progressing the evidence base for suicide prevention and good practice.

The recommendations remain timely as the National Suicide Prevention Strategy (NSPS) enters its next phase, and as the National Mental Health Strategy is being re-considered. This new phase presents opportunities for refining and redefining goals in light of current and past activities (NACSP, 2004). Some of the recommendations are already acknowledged within the *LIFE* framework's action areas, while other recommendations are not currently acknowledged within the framework.

A great deal has been already been achieved by the NSPS. In line with the *LIFE* framework, a broad range of national projects has been initiated that take a community capacity building approach to suicide prevention. In addition, over 140 local community suicide prevention projects are funded under the NSPS (NACSP, 2004). However, SPA recognises the need for a close working arrangement between these strategies, and also other major national health strategies (e.g. relating to drug and alcohol, crime, homelessness etc).

It is important to note that SPA conference delegates were simply asked to indicate their recommendations for suicide prevention. For the most part, attention was not afforded to how the recommendations might be achieved. As a result, the recommendations, and SPA's submission to this inquiry, focus primarily on outcomes, not processes. Nevertheless, SPA intends for this to be considered as a "work in progress" and anticipates that further work will include a focus on processes.

## RESPONSES TO THE TERMS OF REFERENCE

**a) The extent to which the National Mental Health Strategy, the resources committed to it and the division of responsibility for policy and funding between all levels of government have achieved its aims and objectives, and the barriers to progress;**

**The need to increase funding for mental health services**

There is strong evidence to show a direct link between untreated mental illness and suicide. Those who suffer with depression, bipolar disorder, schizophrenia and other psychiatric conditions continue to die at rates vastly higher than that of the general population (Appleby, 2000). SPA strongly believes that suicide rates will not significantly decline in Australia without addressing the mental health problems of Australians.

Outcome 2.2 of *LIFE* aims to reduce the prevalence of known risk factors for suicide and self-harm. SPA acknowledges that a significant number of projects currently funded under the NSPS aim to address mental health issues among the Australian population.

Nevertheless, it is considered that the Commonwealth and States must provide increased funding for mental health services to enable services to operate effectively in relation to need. Currently this does not occur, with an increasing service resource crisis presenting significant threats to the needs and rights of mentally ill people. While mental health disability accounts for 27% of all disability (Mathers et al, 1999), Australia spends less than 7% of the health budget on mental health (Commonwealth Department of Health and Ageing, 2003).

A number of NSW psychiatrists working in the public sector (of whom the Chair of SPA is one) believe that the continuing crisis in mental health services presents a significant threat to the rights of mentally ill people. The manifestations of the crisis in the NSW mental health system and workforce are not dissimilar in other states. The psychiatrists' response to the recent HREOC/MHCA 2004 enquiry concerning the state of mental health services, is reproduced here, as follows:

1. *Overall staffing levels*

   Numbers of trained and experienced staff have been critically reduced, a trend which has been superimposed on chronic understaffing. This is so for most categories of mental health professionals, but particularly psychiatrists, psychiatric registrars and nurses. An additional problem is the limited pool of professionals that can be recruited to the field, even if money were available. As a consequence of these factors, viability of overtime rosters is in jeopardy, risking the safety of patients and registrars. Also, rosters are becoming increasingly onerous for consultants.

2. *Beds*

The inpatient system comprises a small number of beds in psychiatric hospitals, and a large number of scattered small acute admission units in general hospitals. For those at the coalface, there is an insurmountable, overwhelming daily challenge searching for beds, arising from a state-wide bed gridlock. Registrars in particular get 'chewed up' trying to find beds. Associated community services have generally contracted and community rehabilitation positions have been lost, resulting in increased pressure on beds and emergency departments. These services are swamped by inexorably increasing caseloads and demands. It is impractical to explore and provide innovative, 'best practice' models of service delivery in such an environment.

3. *Safety*

These problems jeopardise patient safety. Every day, there are knife-edge situations that generally do not end in disaster, only because of the extraordinary efforts of frontline personnel. It is difficult to act in the patient's best interest when institutional pressures are so great.

Public attention rightly focuses on patient safety but not sufficiently on safety of mental health personnel, with regular assaults on staff being ignored in the media. Current services were not designed to accommodate highly dangerous patients or persons in social crisis who are violent. An overweening focus on safety issues ultimately will degrade the humanistic base of psychiatry, with fear driving a wedge between patients and personnel.

4. *Heightened expectations, demands, and increasing clinical work burden*

There is an increase in complex presentations, drug problems and violence, and the re-emergence of an alienated 'underclass' whose problems are passed off to psychiatry. Human service institutions (e.g. DOCS) increasingly expect public mental health to pick up the tab for social (rebadged as 'mental health') problems.

Although the policy shift to prevention and increasing community awareness of available interventions is laudable, an unforeseen consequence for existing services is the generation of more referrals in addition to providing services to "core" patients in high risk groups.

The prevention 'push' often has encouraged the funding of short-term projects that risk increasing expectations without interventions being sustainable. Such funding enhancements generally have not generated ongoing new mental health services. In addition, other effective sources for referral have diminished. GPs are often too busy and funding constraints limit the availability of the private sector.

5. *Increasing administrative work burden*

   A perception exists that with increasing complexity, health services have become administratively 'top-heavy'. The balance between front-line clinical and administrative staff needs to be reconsidered, and the tendency for management demands to draw the time of senior clinicians away from clinical involvement.

   There is an increasing mass of routine mandated meetings and paperwork, including data collection whose purpose is not always clear. This latter impost is 'resource-neutral', requiring substantial time to be allocated from direct clinical service work.

6. *Threats to quality of registrar training*

   Service demands (e.g. registrar rosters) jeopardise training requirements. Safety issues and adverse confrontations with patients and families relate to inadequate resources and unrealistic expectations.
   There is a lack of diversity in work experiences.

   Barely workable registrar rosters jeopardise registrars' training requirements and/or mental health, leading to resignations, negative perceptions of psychiatry, and problems with recruitment and retention. The current pattern poses a growing risk to a sustainable, home-grown psychiatric workforce for the public sector in the future.

7. *Legal*

   Trends in legal and coronial accountability continue to place psychiatric registrars and consultants as well as other mental health professionals in an invidious situation in relation to their professional, ethical and legal responsibilities.

   In the current climate of legal 'retribution', there is a movement away from genuine clinical governance and leadership guided by professionalism, discretion, judgement and human-focused administrative support, towards top-down management, surveillance and an attempt to codify and prescribe how to manage every predicament however complex.

   In identifying responsibility for errors, the focus typically is on the role of individual clinicians, rather than on dysfunctional systems (cf. the recent Campbelltown debacle). There is a perception that the hierarchy in health does not encourage a culture of transparency or one that allows employees (who, it should be noted are professionals), to speak openly about their concerns. There is a perceived lack of protection for whistleblowers even though, technically, such administrative protection exists in principle. Trust and loyalty are

disappearing from institutions where previously lengthy tenure of staff, particularly psychiatrists, was the norm.

8. *Teaching environments*

   There has been an erosion of the notion of the teaching hospital. Previously, psychiatrists in these settings had a diversity of activities (an attraction that lured them away from more lucrative private practice careers). Teaching, research, self-directed learning, community leadership and other activities were seen as integral to the public service role. Now, clinical pressures have overwhelmed all other roles. In addition, there has been a fragmentation in the overall mission of the teaching hospital. The environment in psychiatric units is no longer conducive to high quality training of future medical practitioners and psychiatrists adding to the difficulty of recruiting new graduates and junior doctors to the specialty of psychiatry.

9. *Accommodation*

   The move to community based services, while positive, has not been matched by attention to stratified and good quality accommodation options for persons with chronic mental illness who rarely can access supervised community accommodation. Disabled and disorganised patients flounder in unsupervised single accommodation, are cast onto the streets, or are involved in "revolving door" admissions to acute units, which are the only “accommodation” facilities remaining for them. A distressingly high number kill themselves.

10. *Public spending*

    Current expenditure in Australia on mental health is about $3.1 billion/year – out of a total health budget of $66 billion. As of end 2002, national mental health spending fell from 6.6 to 4.5% of total health spending. This trend represents a visible lack of commitment to the mentally ill and their welfare. Available indices suggest that NSW public mental health services may be disproportionately underfunded, compared with the national picture.

    Hence the increasing service resource crisis presents significant threats to the rights of mentally ill people. This occurs through compromising safety and increasing the risk of sub-standard treatment, undermining centres of clinical academic excellence, increasingly marginalising those with mental illnesses, and through a tendency when addressing clinical problems to rely increasingly on administrative and legal solutions rather than clinically led solutions. The adverse factors combine to make front-line public mental health professionals an endangered species.

    Identifying the issues is the first step in the process of planning a better public mental health services. There is a pressing need for leadership at all levels to find such solutions to address the critical state of mental health services”.

In response to this situation, SPA is in agreement with the position of the Mental Health Workers Alliance (MHWA). The MHWA represents members of the Police Association, the NSW Nurses Association, the Australian Salaried Medical Officers Federation, the Health Services Union and the Australian Services Union.

The Alliance calls for an end to blame shifting between the state and federal levels of government and calls for a coordinated approach. It emphasises that efforts must be made to address the impact of system failure on those living with mental illnesses, their carers, and all front line workers struggling to provide first class care in an under-resourced and poorly coordinated industry. Front line health, police, emergency, and community care workers are faced with the shortcomings of the mental health system every day and are among the best placed to highlight areas where change is most needed.

**SPA with the Alliance advocates a Five Step Program for a Saner Mental Health System, namely:**

a. Appropriate funding for mental health by increasing the mental health proportion of the State health budget to at least 12%, as recommended by the Mental Health Council of Australia, and for mental health expenditure to be transparent and quarantined.

b. Better resourcing for long term supported accommodation options for all people with mental illnesses, including homeless people.

c. Increasing the capacity of inpatient units and community services to guarantee 24 hours access to those in need of treatment

d. Appropriate crisis care, including 24 hour mental health expertise in emergency departments and community teams, to alleviate pressure on front line emergency services.

e. Addressing the problems of recruitment and retention in the sector by providing incentive to enter employment, enhancing access to training schemes, and providing support for learning and development opportunities.

**b) The adequacy of various modes of care for people with a mental illness, in particular, prevention, early intervention, acute care, community care, after hours crisis services, and respite care;**

**1. Those attempting suicide need appropriate interventions to prevent recurrence (see also TOR l.)**

Patients who attempt suicide are more likely to re-attempt and to die by suicide than those who do not attempt suicide. They frequently suffer from mental illnesses. Those who are actively followed up after presenting to an emergency department with suicidal behaviour may be less likely to repeat their action and more likely to gain access to appropriate treatment (Brent et al., 1993; cited in Commonwealth Department of Health and Aged Care, 2000b).

The management of patients with deliberate self-harm largely occurs on an ad-hoc basis in Australian hospitals. The patient is commonly managed in the Emergency Department and not every patient receives formal psychiatric assessment (Whyte, Dawson, Buckley, Carter & Levey, 1997).

Following a suicide attempt, a range of interventions is important in the prevention of further suicide attempts. These include:

- Conducting a full medical and psychiatric assessment following presentation;
- Following-up all attempters and maintaining a register;
- Encouraging all suicide attempters, through public awareness programs, to seek treatment;
- Including a full risk assessment in all assessment of suicide attempts;
- Inclusion of a care plan; and
- Making 24-hour emergency services available and accessible for suicidal individuals, those mentally distressed and for periods of crises.

Outcome 4.1 of *LIFE* aims to improve emergency response and provision of follow-up support for incidents of attempted suicide and self-harm. Six local projects are currently funded by the NSPS in this area. There are currently no national level initiatives underway in this area.

Some of the strategies listed under this outcome area relate to the above recommendation. For example, one suggested strategy is to establish protocols and procedures for emergency services focusing on an enhanced commitment to the response and follow-up process after an incident of attempted suicide or self-harm, including the linkages between community and hospital-based services (Commonwealth Department of Health and Aged Care, 2000b).

**SPA considers there is a need for all hospital based services to:**

- Admit all patients who present with deliberate self-harm to enhance clinical responsibility and data collection;
- Co-ordinate medical, surgical and psychiatric treatment within the ED and wards;
- Offer a psychiatric assessment to all deliberate self-harm patients;
- Implement existing Clinical Practice Guidelines and evaluate and report on the extent to which they are used; and
- Provide adequate follow-up services including mental health, addiction, relationship services, social services and housing, and evaluate the extent to which these follow-up services are used and how well they are deployed.

**SPA also recommends that independent research be undertaken to determine:**

- the quality of outcomes that are being achieved through the implementation of strategies listed under Outcome 4.1 of the *LIFE* framework; and
- the extent of compliance by service providers with existing guidelines and protocols for emergency response to suicide attempts and self-harm and actions that may be taken to enhance compliance with such standards and protocols.

**2. There is a need to enhance support and interventions for those who have been recently discharged from an inpatient psychiatric facility (see also TOR n.& o., at 9))**

For those discharged from an inpatient psychiatric facility, there is a well-recognised period of high risk of suicide, occurring in the weeks afterwards.

**SPA considers that:**
Community mental health services need to be adequately resourced to follow-up those discharged into the community who are at risk of suicide (see also TOR a., above).

**3. There is a need to enhance depression awareness, recognition and treatment (see also TOR h.)**

It is well established that depression is one of the strongest risk factors for suicide and self-harm (Lonnqvist, 2000). Outcome 4.2 of the *LIFE framework* is to reduce the risk of suicide and self-harm among people with, or at high risk of, mental disorder.

A number of projects aimed at addressing the needs of people with a mental illness have already been initiated under both the NSPS and the National Mental Health Strategy (NMHS). For example, to enhance depression awareness, the Australian Rotary Health Research Fund aims to improve community understanding of mental illness through community service announcements and hosting community information forums on mental illness. In addition, eight local projects are funded by the NSPS in this area.

**While much has already been achieved in this area, SPA considers there is a need for strategies under Outcome 4.2 of the LIFE framework to:**

- Assess what GPs need to deliver effective service;
- Ensure that medical students, doctors, nurses, and related professionals including prison officers, teachers, welfare officers and human resource managers receive appropriate training in depression awareness recognition and treatment;
- Encourage development of individual, peer and group support and help line counselling services in tertiary institutions; and
- Continue to enhance public awareness of depression, its consequences and the need for treatment.

**f) the special needs of groups such as children, adolescents, the aged, Indigenous Australians, the socially and geographically isolated and of people with complex and co-morbid conditions and drug and alcohol dependence;**

This term of reference links closely with Action Area 3 of LIFE, which aims to improve the ability of a wide range of services, service systems and support networks to meet the needs of groups at increased risk of suicide and self-harm, through prevention, recognition and response.

The following recommendations are relevant to this third action area:

i. There is a need to provide culturally appropriate programs which support community responses to the challenges confronting Aboriginal and Torres Strait Islander communities.
ii. There is a need to increase efforts to reduce the suicide rate in young males
iii. There is a need to enhance support for people bereaved or directly affected by suicide.
iv. There is a need to heighten public awareness and recognition of alcohol related problems and the link between alcohol abuse, depression and suicide; and to reduce the number of people engaging in the use of illicit drugs
v. There is a need to provide ready access to mental health services for males in rural areas
vi. There is a need to increase awareness of the impact of life crises and to ameliorate their effect
vii. There is a need to increase efforts to reduce the suicide rate in people over 75 years
*viii.* There is a need to improve awareness, recognition and treatment of psychiatric illness, mental distress and suicidal ideation and behaviour in people with physical illness

## 1. *Aboriginal and Torres Strait Islander peoples*

Action area 5 of the LIFE Strategy concerns partnerships with Aboriginal and Torres Strait Islander peoples. The aim of this action area is to provide culturally appropriate programs (universal, selective and indicated) which support community responses to high rates of suicide, substance misuse and other challenges to social and emotional well-being in Aboriginal and Torres Strait Islander communities.

More work is needed to provide culturally appropriate programs to Aboriginal and Torres Strait Islander communities. The following recommendations are relevant to this fifth action area:

- The implementation of the National Strategic Framework for Aboriginal and Torres Strait Islander Peoples Mental Health and Social and Emotional Well Being 2004-2009 should be adequately resourced
- There is a need to build an effective workforce across all sectors that recognises, values and enhances the capacity of Aboriginal communities, organisations and government agencies to respond to the mental health and suicide prevention issues
- There is a need to actively promote the sharing of success stories and publicise these broadly
- Aboriginal and Torres Strait Islander communities should be involved in partnership across all aspects of mental health and suicide prevention initiatives to ensure learning exchange ultimately benefits the recipients
- There is a need to promote and preserve family life through kinship systems and traditional owners, and recognise when these systems are broken down so that these can be revitalised.
- All research and evaluation work relevant to Aboriginal health should meet certain requirements
- There is a need to support community based suicide prevention initiatives

### i) The implementation of the National Strategic Framework for Aboriginal and Torres Strait Islander Peoples Mental Health and Social and Emotional Well Being 2004-2009 should be adequately resourced

Aboriginal and Torres Strait Islander peoples are over-represented in suicide deaths (see further below). The Australian Government recently developed the National Strategic Framework for Aboriginal and Torres Strait Islander Peoples Mental Health and Social and Emotional Well Being 2004-2009.

- Given the wide range of issues facing Aboriginal and Torres Strait Islander communities and constraints in resources, SPA considers there is a need to ensure that this Framework is adequately resourced.

**ii) There is a need to build an effective workforce across all sectors that recognises, values and enhances the capacity of Aboriginal communities, organisations and government agencies to respond to the mental health and suicide prevention issues.**

A range of Indigenous NSPS initiatives have been developed and progressed in partnership with the Indigenous Strategies Working Group. In addition, in 2003 a national Aboriginal and Torres Strait Islander Suicide Prevention Initiative was developed.

*While acknowledging the progress that has been made to date under the NSPS, SPA considers that important components of Indigenous suicide prevention initiatives are:*

- Mandatory placements for students of the mental health related professions to work within Aboriginal and Torres Strait Islander communities that have a desire to be involved;
- To recognise and adequately fund the diversity of community driven approaches that are relevant with common ingredients; and
- To support the development of Aboriginal Health workforce training programs around Australia that are based on established standards (e.g. National Mental Health Practice Standards). The Charles Sturt University Djirruwang Program should be used to inform the development of similar programs[1].

**iii) There is a need to actively promote the sharing of success stories and publicise these broadly.**

Identifying and documenting the processes involved in the success stories is important in order to recognise the learnings that will assist community capacity building.

Outcome 5.1 of the LIFE framework is to share information about and implement life-affirming and suicide prevention programs that are community based and grounded in the culture of Aboriginal and Torres Strait Islander peoples. Currently, 21 local projects are funded by the NSPS in this area.

As part of the National Aboriginal and Torres Strait Islander Suicide Prevention Initiative, Indigenous writers have been contracted to develop culturally appropriate information about suicide prevention, intervention and postvention.

SPA considers that this information should include a focus on the promoting and publicising of success stories within Aboriginal and Torres Strait Islander communities.

[1] The Djirruwang Program delivers a three-year Bachelor of Health Science. Course entry is restricted to Aboriginal and Torres Strait Islander people. Since commencement in 1993, the program has contributed significantly to the mental health workforce, with 70 students having graduated from the course (Brideson & Kanowski, 2004).

***iv)*** **Aboriginal and Torres Strait Islander communities should be involved in partnership across all aspects of mental health and suicide prevention initiatives to ensure learning exchange ultimately benefits the recipients**

Research shows that many Aboriginal people believe that mental health problems are a major concern for their communities (Vicary & Westerman, 2004). Indigenous people are, however, concerned that western models of treatment will not account for Indigenous beliefs about mental illness. To overcome these concerns and to ensure cultural relevance and appropriateness, Aboriginal and Torres Strait Islander communities should be encouraged and assisted to design culturally appropriate mental health services in partnership with non-Aboriginal practitioners (Vicary & Westerman, 2004).

As already mentioned, Indigenous strategies under the NSPS are developed in partnership with Indigenous communities through the Indigenous Strategies Working Group.

SPA commends the work achieved to date by this group and considers there is a continued need for Indigenous mental health and suicide prevention initiatives to be developed in partnership with Aboriginal and Torres Strait Islander peoples.

***v)*** **There is a need to promote and preserve family life through kinship systems and Traditional owners and recognise and repair when these systems are broken down so that these can be revitalised**

Under the NSPS, initiatives have targeted Indigenous communities as a whole, as well as focusing on different sub-groups of communities, including Indigenous family relationships.

SPA considers that evaluation of these projects is required to determine their effectiveness.

**vi)** **All research and evaluation work relevant to Aboriginal health should meet certain requirements**

These include:

- Intrinsic community benefit directly resulting from the research or some form of negotiated compensation for participation (not necessarily money);
- Involvement early in the development of the project;
- Appropriate acknowledgement, reporting and shared ownership of the intellectual property; and
- Involvement in any subsequent decision-making related to the outcomes of the research.

SPA considers there is a need for all initiatives under the NSPS to meet these requirements.

**vii) There is a need to support community based suicide prevention initiatives, especially in remote communities**

Aboriginal and Torres Strait Islander peoples are over-represented in suicide deaths. In 2002, Aboriginal and Torres Strait Islanders made up almost 5 per cent of suicides, yet they comprise just 2.4 per cent of the total Australian population (NACSP, 2004). Moreover, while the suicide rate in the general population has remained relatively stable over the last century, the rate of suicide in Aboriginal communities is generally increasing (Elliott-Farrelly, 2004).

People in indigenous remote communities in particular face a particularly difficult and tragic situation regarding suicide. The significant cultural differences between 'western' and indigenous understandings, and the diversity within Aboriginal peoples regarding suicide, are hard to negotiate. The issue is particularly poignant, as it cuts through to 'life & death' - often the source of deepest cultural ritual and 'taboo'. Given the often impulsive and lethal nature of the act, reducing the tragic rate of suicide by young Aboriginal males, requires good community awareness of the situation and very prompt, effective containment.

SPA suggests that government as a priority consider appropriate 'grass roots' suicide prevention training in all high risk groups, with funding to include appropriate support for collaboration with an appropriate research\evaluation centre (eg. regional universities) and adequate length of funding to discern changes.

**2.** ***There is a need to increase efforts to reduce the suicide rate in young males***

Males are far more likely than females to die from suicide. For every one female suicide death there are approximately for male suicide deaths (ABS 2002; cited in NACSP, 2004). Since 2000, 31 local projects totalling $4.5 million have been funded under the NSPS directly addressing suicide prevention for males.

**In order to build on the work that has already been done, SPA considers there is a need for evaluation of current projects to determine the extent to which the programs:**

- Improve self-esteem and reduce alienation;
- Promote a problem-solving approach to life crises;
- Encourage prompt treatment of suicide attempts;
- Encourage the need to take all destructive behaviour seriously;
- Extend suicide prevention to young males outside the education and employment network;
- Improve the educational qualifications of young males; and

- Increase the employment conditions of young men (possibilities include work-related training programs, apprenticeship opportunities and employer incentives for training).

**SPA further considers that additional projects should be funded under the NSPS to develop:**

- New models of appropriate counselling and psychotherapy for men and boys;
- Accredited tertiary level psychology and welfare courses in men's issues; and
- An appropriate workplace culture of support for men.

### 3. *There is a need to enhance support for people bereaved or directly affected by suicide*

The impact of suicide reaches far beyond the person who takes their own life. Supportive interventions are needed for families, schools, workplaces, communities and professionals affected by suicide. Given increased rates of suicide for people in this situation, the focus must be on containing suicide risk as well as providing bereavement support (Commonwealth Department of Health and Aged Care, 2000b).

Outcome 4.5 of *LIFE* is to provide support for people bereaved or directly affected by suicide. Six projects are currently funded under the NSPS that are directly aimed at those bereaved by suicide. SPA considers that independent evaluation of these projects is required to determine their impacts. In particular, evaluation of the projects should show that family and friends are consistently included as people affected by suicide, and that expert grief counselling and other measures are routinely made available and promoted.

**SPA further recommends that services for people bereaved by suicide:**

- Are diverse and accessible;
- Are appropriate for all geographic locations and all times of the day and night (Clark, 2000);
- Are appropriate to those with special needs such as children, youth, indigenous and the gay and lesbian community (Clark, 2000);
- Have a trained person as the first point of contact;
- Are co-facilitated by a professional and a bereaved person (both who receive training);
- Include an outreach support service to the bereaved immediately after the suicide which includes a bereavement support and information pack (Clark, 2000);
- Enhance the effectiveness of support groups and sustain volunteers within these groups (Clark, 2000);
- Establish crisis plans and postvention programs for schools (Clark, 2000);
- Include guidelines, protocols and risk management procedures; and
- Have a system of co-ordination, a service directory and appropriate funding.

**SPA also supports the following recommendations by Clark (2000) in relation to support for people bereaved by suicide:**

- There is a need to provide funding to support the creation of new services and the improvement of existing services to assist those bereaved by suicide;
- There is a need to promote education about suicide bereavement to:
  - * All professionals and service providers concerned with the aftermath of suicide as well as support group workers and teachers;
  - * The general public, in order to change community attitudes and to increase community support for the bereaved;
  - * Raise the profile of suicide bereavement as an important issue within the community
- There is a need to establish standards of care, including guidelines, accreditation and supervision systems for service providers and support groups;
- There is a need to consult with bereaved consumers on matters pertaining to policy and service provision;
- There is a need to identify successful role models, public leaders and politicians who will advocate for those bereaved by suicide;
- There is a need to enhance support for professionals and service providers affected by a suicide;
- There is a need to increase research in suicide postvention to provide direction for service provision; and
- There is a need for SPA to act as a vehicle for developing suicide postvention strategies.

**4.** ***There is a need to heighten public awareness and recognition of alcohol related problems and the link between alcohol abuse, depression and suicide; and to reduce the number of people engaging in the use of illicit drugs***

Harmful alcohol and other drug use is associated with increased suicide risk. When combined with mental health problems the risk increases (NACSP, 2004).

Outcome 4.4 of *LIFE* is to reduce the risk of suicide and self-harm associated with harmful drug and alcohol use. Under the NSPS, seven local projects directly target the use of alcohol and other drugs. For example, funding has been directed to enhancing services for individuals engaged in harmful drug or alcohol use (NACSP, 2004).

**While SPA commends the achievements in this area to date, it is considered that independent research is needed to determine the extent to which the current projects:**

- Effect a reduction in the national alcohol consumption levels;
- Ensure that all individuals who seek treatment for alcohol problems are fully assessed for depressive illnesses, other psychiatric disorders and suicide risk;
- Continue to reduce access to illicit drugs; and
- Emphasise the risk of precipitating suicidal behaviour or psychiatric illness with illicit drug use.

**SPA further considers there is a need to:**

- Intensify educational and awareness programs directed at young people and at parents/carers regarding illicit drug use;
- Provide the pharmaceutical industry with training, education and awareness of the links between drug use, depression and suicidal behaviour; and
- Provide pharmaceutical staff and retailers with training, education and awareness of the links between drug use, depression and suicidal behaviour, and to identify individuals at risk who present (to purchase drugs).

**5.** ***There is a need to provide ready access to mental health services for males in rural areas***

Suicide rates for young males (aged 15 to 24 years) have been consistently higher in rural areas than in metropolitan and rural areas (Dudley et al., 1998). Moreover, evidence suggests that suicide rates for males in rural and remote areas have increased over the past 20 years (NACSP, 2004).

People in rural and remote communities experience specific risk factors such as limited access to services, communication difficulties and isolation, all of which can impact upon feelings of connectedness and lead to mental health problems (NACSP, 2004).

Outcome 3.3 of *LIFE* focuses on suicide prevention in rural and remote communities. Significant progress has already been made in this area. For example, a number of local projects have aimed to reduce risk factors for males living in rural and remote areas by implementing multi-dimensional intervention programs aimed at building resilience through skills development. Other programs have focused on males from culturally and linguistically diverse backgrounds living in rural areas, a group that has been identified as being at high risk.

Community-based suicide prevention requires each community to have sufficient numbers of people who are 'aware' of risks and confident enough to do something about it. This inherently 'grass roots' approach is only possible if appropriate training is made available to community members. As with first aid, the best chance that people trained in suicide prevention will use their skills, is by providing good quality initial training, linking them to support, and providing follow-up refresher workshops.

While many projects have been initiated in this area, SPA considers there is a need for independent research to determine the quality of the outcomes being achieved through the implementation of these projects. As noted above, SPA also suggests that government consider 'grass roots' suicide prevention training, with funding of sufficient amount and duration to include collaboration with an appropriate research centre (eg. regional universities) and to adequately evaluate changes over time.

**6.** ***There is a need to increase awareness of the impact of life crises and to ameliorate their effect***

People experiencing a life crisis are at increased risk for suicidal behaviour. Events or factors that may precipitate suicide or suicidal behaviour include relationship breakdown, a trauma in the family, financial problems, military service, marital separation or divorce, legal problems, imprisonment, interpersonal problems and disputes, sexual difficulties, moving house, school or job, or personal illness (Commonwealth Department of Health and Aged Care, 2000c). Services and support are essential for individuals who experience such a pivotal event.

The **LIFE Framework** does not currently include a focus on people who experience a life crisis.

**SPA considers there is a need for the Framework to be broadened to include such a focus. In particular, there is a need for LIFE to explore the extent to which:**

- Post-separation counselling is effective;
- Support, retraining and job search facilities are available for the unemployed;
- Courses are available on coping with retirement;
- Mental health problems are currently monitored and addressed in refugee populations;
- Remand and sentenced prisoners receive initial and ongoing monitoring of their mental health and suicide risk; and
- Bullying is adequately addressed in educational facilities and the workplace.

**7.** ***There is a need to increase efforts to reduce the suicide rate in people over 75 years***

Statistics show that in many countries around the world, the highest rate of suicide is in people over the age of 65 years. Elderly people with mood disorders such as depression are at even greater risk (Harwood & Jacoby, 2000). In Australia, there has been significant reduction in suicide rates among those aged 55-74 years, but continuing high rates among those over 75 years. Given the rising population of older people, a strategic approach to suicide prevention in this age group is essential.

Under the NSPS there are currently 11 local projects targeting suicide in older Australians.

**SPA considers that independent research is required to determine the extent to which these projects:**

- Encourage prompt recognition, treatment and long-term management of depression;
- Increase public awareness of suicide as an issue in the elderly;
- Encourage GP's and other medical professions to provide families with an awareness of suicide as an issue in the elderly;
- Emphasise that depression in old age is not inevitable;
- Promote social connectedness and social support;

- Provide assistance with crises, such as retirement, death of a spouse, illness and loneliness; and
- Promote late life as a valuable time in the life cycle.

**8.** ***There is a need to enhance the coping skills of families in distress***

Family disruption and stress, such as a death in the family, domestic violence and separation, can increase risk of suicidal behaviour. Martin, Rozanes, Pearce & Allison (1995) founds that adolescents' experiences of family dysfunction were associated with depression which, in turn, influenced suicidal behaviours.

Outcome 2.1 of *LIFE* aims to enhance factors that protect against adverse social conditions associated with suicide risk. Currently 25 local projects are funded in this area under the NSPS.

**SPA acknowledges that a great deal of work is being undertaken in this area and considers that evaluation of these projects is required to determine the extent to which the projects:**

- Enhance the coping skills of at-risk families;
- Provide more support services to families at times of separation and conflict;
- Provide more specific and co-ordinated support to relatives of suicide victims; and
- Provide ready access to support services for families experiencing a suicide attempt, depression, substance problems or mental illness.

**9.** ***There is a need to improve awareness, recognition and treatment of psychiatric illness, mental distress and suicidal ideation and behaviour in people with physical illness***

Physical illness is a crisis in an individual's life and so it is essential that it is appropriately assessed and managed. Research has shown that a range of physical disorders are associated with an increased risk of suicide and suicide attempts (Stenager & Stenager, 2000).

The *LIFE* Framework does not currently address the issue of increased suicide risk among people with physical illness. SPA considers that a mental state and suicide risk assessment should be conducted for all persons with a serious physical illness. Pain management, knowledge about the illness, good palliative care, and clear delineation of the continuity of care plan should be an integral part of good management.

SPA considers there is a need for the Action Area four of the *LIFE* Framework to be broadened to include a focus on persons with a serious physical illness.

**h. The role of primary health care in promotion, prevention, early detection and chronic care management.**

1. There is a need to enhance depression awareness, recognition and treatment (see b)

**i. Opportunities for reducing the effects of iatrogenesis and promoting recovery-focussed care through consumer involvement, peer support and education of the mental health workforce, and for services to be consumer-operated;**

(see also response to b. )

From a suicide prevention focus, iatrogenesis includes situations where mental health systems are unable to provide the level of support that could reasonably be expected for a person at risk, and the person subsequently completes suicide. Examples of groups at risk include those presenting to health services having self-harmed, and those recently discharged from an inpatient psychiatric facility (there is a well-recognised period of high suicide risk, occurring in the weeks afterwards).

The suicide rate for people diagnosed with almost any mental disorder is higher than the general population, substantially so for some disorders (e.g. depression).There is reasonable evidence that subjective 'hopelessness' can be a significant risk factor for suicide. Significant psychiatric disability, with the accompanying social stigma and marginalization can fuel hopelessness.

Recovery-focussed approaches and consumer-operated services are potentially useful 'antidotes for hopelessness' for a number of important reasons – 1) the underlying philosophies are inherently optimistic and client-focussed; 2) the frameworks expect active collaboration and participation, not passive or dependent recipients of treatment; 3) the latter in particular, fosters socialization, co-operative advancement and mutual support for a sub-population characterized by isolation.

Consumer operated organizations also provide the potential for community level suicide prevention. Some organizations (eg. GROW) have mutual support as a core principle and may have well-developed, 'built-in' support systems (e.g. new members having a defined mentor or buddy). It is likely such organizations save many lives each year, through the varied formal and informal attachments formed between consumers. Further value could be added by making available specifically prepared education and training in suicide prevention to this sector (see also response for T.O.R. f. ). A sound level of clinical knowledge and appropriate review processes is recommended for the design and presentation of such training.

Regarding the development of recovery-focused services in general, a significant obstacle across government and non-government sectors is poor development and application of appropriate skills to implement the strategies. Across the government mental health sector over the last 20 years, there has been a movement away from involvement in 'rehabilitation', and widespread devolution of vocational and psycho-social 'programs'. Provision of such services is a major area of development for Non-Government Organizations (NGO), including consumer operated services. Concurrently, there has been increasing evidence regarding the utility of cognitive-behavioural based approaches for improved self-management of the symptoms of many mental disorders.

The success of efforts by NGO's to implement effective recovery-focussed programs, will ultimately depend on their workforce skill capacity. Negotiating and implementing a recovery-focused approach with a consumer experiencing significant disability associated with a mental disorder may be a challenging process. At its foundations, the approach is facilitated learning – the consumer learns to 'cope' better. This would suggest that the chances of success are improved if the practitioner has good knowledge and experience in the following: recognising symptoms of mental disorders, flexible engagement skills, human motivation and learning, symptom control strategies, and facilitating behavioural change. The risk may be that the tight budgets of NGO's, which so often compromise the skill level of employees applying for positions, may result in poorly implemented programs. Such examples will reduce the perception of the effectiveness of the approach and over time, discourage all parties (funders included).

**There are potentially many options that may limit the above risk. SPA suggests one possible approach as follows:**

i) a nationally co-ordinated approach to promoting recovery, with a limited number of grants available for establishment of services, tied to conditions.
ii) adoption of standards regarding recovery-focussed approaches which specified the quality and type of training required by the workforce and a mandatory evaluation framework with periodic reporting.
iii) This would allow a period of evaluation of a small number of targeted projects, to inform decisions regarding further resource allocation.

**j. The overrepresentation of people with a mental illness in the criminal justice system and in custody, the extent to which these environments give rise to mental illness, the adequacy of legislation and processes in protecting their human rights and the use of diversion programs for such people;**

1. **There is a need to reduce the suicide rate in prisons and police custody**

Legal problems are associated with increased risk of suicide before, during, or after trial or imprisonment (Beautrais 1998; cited in Commonwealth Department of Health and Aged Care, 2000b).

Outcome 4.3 of *LIFE* aims to enhance support for people who are involved with, or likely to become involved with, the criminal justice or juvenile justice system. Ten projects have been funded under the NSPS which target correctional and youth detention centres, juvenile justice, police, inmates, families and ex-prisoners (NACSP, 2004).

**While SPA acknowledges that projects are currently in progress, SPA considers there is a need for independent evaluation of these projects to determine the extent to which the projects:**

- Promote psychiatric evaluation of all remand and sentenced prisoners;
- Enhance the prison psychiatric services in terms of assessment, monitoring and treatment;
- Promote the training of prison staff in counselling services;
- Address alcohol abuse and illicit drug use; and
- Explore the possibility of video surveillance of high suicide risk prisoners.

***2.*** **There is a need to address the mental health needs of those in immigration detention**

SPA has long been profoundly concerned with the mental health needs of those in Australian immigration detention. At this writing, this issue is firmly in the public eye. The prolonged illegal incarceration of a mentally ill Australian woman, Cornelia Rau, the wrongful deportation of another mentally ill Australian woman, Vivien Alvarez Solon, and the removal of schoolchildren in front of their classmates by DIMIA officers, are the latest actions that have been widely reported in the media. Consistently Minister Amanda Vanstone in her press statements has illustrated ignorance of mental illness. She has defended the Department's actions on the basis that "the person lied; they gave a false name" or that "Cornelia did not want to go to the Glenside Hospital and wanted to stay at Baxter". One can only assume her advice from the Department lacks understanding of mental illness. These developments have led to calls for a Royal Commission into the workings of DIMIA (see further below).

Australia's system of indefinite mandatory detention for asylum-seekers and other non-citizens is a system unparalleled elsewhere in the world. Detainees experience indefinite immigration detention as depriving them of their culture, identity and humanity. There is overwhelming evidence that it creates and maintains mental illnesses, and that these illnesses are more frequent in immigration detention centres (IDCs) than those seen in any modern society. Multiple independent inquiries by the UN, Amnesty, Human Rights Watch and the Human Rights Commission (HREOC) extensively document and agree on the mental health effects of indefinite detention, and the regular violation of basic human rights standards. The latest of this series was the painstaking HREOC report 'A last resort? National Inquiry into Children in Immigration Detention', released 12 months ago.

Several scholarly research studies have also confirmed and extended the findings. In ten asylum-seeker families held for protracted periods in a remote IDC, all adults and children met diagnostic criteria for at least one current psychiatric disorder with 26 disorders identified among 14 adults, and 52 disorders among 20 children. Persistent suicidal ideation was reported by all but one adult, and over half the children; five adults and five children had engaged in self-harm or attempted suicide. Retrospective comparisons indicated that adults displayed a threefold and children a tenfold increase in psychiatric disorder subsequent to detention. Exposure to trauma within detention was commonplace. All adults and the majority of children were regularly distressed by

sudden and upsetting memories about detention, intrusive images of events that had occurred, and feelings of sadness and hopelessness. The majority of parents felt they were no longer able to care for, support, or control their children. The authors concluded that detention appears to be injurious to the mental health of asylum seekers, and the level of exposure to violence and the high level of mental illness identified among detained families provides a warning to policy makers about these effects (Steel et al, 2004; see also Mares et al, 2002). Self-harm is a highly significant problem (Dudley, 2003). Consecutive case series (Mares and Jureidini, 2004) and participant observer research (Sultan and O'Sullivan, 2001) also suggest that over the months and years of waiting, IDC's destroy detained families' lives and children's trust in the goodness of the world.

Church leaders, lawyers, doctors, educationalists and the overseas press have also criticised the policy and practice, along with thousands of ordinary Australians. Liberal backbenchers recently visited these centres and said there must be change.

Yet the recommendations of these inquiries and research studies, and the weight of these community leaders have been repeatedly ignored. These practices continue with impunity. Many children in particular are still held in immigration detention (81 as of 24th March 2005, according to ChilOut). The Federal government has consistently denied evidence of harm and ignored repeated calls (by SPA and the Royal Australian and New Zealand College of Psychiatrists, among others) for an independent inquiry into the mental health of detainees. Attempting to discredit the available scientific research, it bypassed competitive tender processes and engaged a psychiatrist (Dr Doran Samuell) for $30,000 to write a report that would supposedly challenge the researchers' methods and ethics. Dr Samuell is unknown in refugee networks and research, is a member of the Liberal Party and had a self-confessed agenda to discredit the findings from the outset. Dr Samuell's accusations of academic misconduct have been found to be completely without substance by an independent university inquiry. His research was awarded without competitive tendering. If the Government were serious about the science, it would have gone to National Health and Medical Research Council, let the experts in to do a proper study, or else commissioned its own (ABC Lateline 9th February, 2005). The recent Federal Court judgement by Justice Finn (S v Secretary, Department of Immigration Multicultural and Indigenous Affairs [2005] FCA 549) also showed that the Commonwealth breached its duty of care to two detainees in Baxter IDC to ensure that reasonable care was taken to ensure treatment of their respective psychiatric conditions.

Mental illness is neglected in immigration detention for a number of reasons. The framework for managing detainees treats them as law-breakers whose behaviour must be deterred. Such a deterrent approach treats suffering and psychological harm to detainees as acceptable 'collateral damage'. Former Minister Philip Ruddock asserted that depression among detainees is not a mental illness, and that self-harm is manipulation (rather than a reflection of despair). He frequently referred to asylum-seeker self-harm 'inappropriate behaviours' and 'moral blackmail', and suggested actions such as lip-sewing stemmed from their cultures and were repugnant to Australians. IDCs are therefore custodial and punitive, rather than being treatment-

based. They resemble prisons in that they hold people under maximum security, use solitary confinement, employ prison staff etc, but differ from them in that the inmates are indefinitely detained.

Further, the professional judgements of health staff are subverted by the custodial and punitive functions of IDCs. Independent health professionals' access to immigration detention centres (IDC's) is extremely limited, and offers from medical and psychiatric bodies to assess need and provide services, have been blocked. There are no effective working agreements between DIMIA and state government departments of health and community services, and major problems for health providers on the outside communicating with their counterparts on the inside. A culture of profit, lack of transparency, and conflicts of interest (the source of the distress provides the service that purports to treat it) affect all health treatment decisions and potentially compromise professional ethics. No appropriate psychiatric treatment can be given, as the environment itself causes the problem. IDCs are run in secret, unreviewable by the usual processes available in a democratic society. DIMIA/ACM/GSL staff not uncommonly have depression and post-traumatic stress disorder, in relation to what they have seen and what they have to do. For the Commonwealth government to accept such psychological harms as 'collateral damage', and to continue the policy without review, amounts to state-sponsored trauma and child neglect and/or abuse. As the above example of Dr Samuell illustrates, questions of corruption also arise.

**With the Alliance of Professionals for the Health of Asylum-Seekers (representing many medical and professional colleges), SPA has called for an end to the current policies, as follows:**

1) indefinite mandatory detention.
2) the so-called "Pacific solution"
3) the temporary protection visa system (which fosters anxiety as it gives the holder no security of tenure)
4) the secret deportations, often to danger, using physical and chemical restraint with psychotropic drugs.

**With the Mental Health Council of Australia, SPA also affirms that the current Palmer inquiry concerning illegal detentions and wrongful deportations is inadequate, and calls for an open, judicial inquiry. This is based on the following:**

i) Only where the rights and legal protections afforded by a properly constituted judicial inquiry will public servants, contractors and other persons of relevance to these cases be willing to devolve the truth and where they do not do so they commit perjury.

ii) The evidence suggests systemic failures across jurisdictions and departments. Any investigations will be complex and will by various laws (privacy and others) restricted in accessing the relevant persons and documents. In some instances, persons who could give evidence will be in breach of those orders should they speak to the media or Mr Palmer. Palmer has no powers to override state or Commonwealth law or compel, seize or subpoena anyone or anything.

iii) The number of illegal detentions and wrongful deportations to be referred to Mr Palmer, and which cases, is at the Minister's/Department's discretion. The question as to which cases Mr Palmer is to investigate, where there are potentially illegal actions by DIMIA, is determined by DIMIA. How Mr Palmer is supposed to know of all the relevant cases and determine which files he should request from the Department is not clear.

iv) Mr Palmer will report to the Minister. The Minister it seems will then determine what of his report is made public. The Minister has referred to privacy concerns of the families as a reason for a closed inquiry. In the case of Vivian Solon, they asked her former husband who has no legal relationship to her. These are spurious reasons in the Council's and SPA's view. A judicial inquiry can determine what evidence is in-camera, as courts in this country do on a daily basis.

v) The MHCA and SPA are aware of a report by the Commonwealth Ombudsman in 2001 which made a number of recommendations, later agreed to by DIMIA, relating to the provision of mental health services in detention centres. There were also recommendations stating that immigration detainees should not be held in state prisons and DIMIA in their reply agreed that these would only be for "exceptional circumstances". It is clear that the DIMIA has not addressed the recommendations of the Ombudsman and only a full judicial inquiry with the power to refer cases of abuse/illegal action to the DPP will succeed.

The Minister at this writing (11/5/05) is continuing to deny the need for an open inquiry. In this context, SPA is supporting the call for a Royal Commission.

In addition, the Federal Court decision (Justice Finn) noted above, has implications for the systemic abuse of people with mental illness by DIMIA, and for all mental health professionals providing services to DIMIA.

**SPA also recommends that:**

*i)* the Prime Minister affirm that the standards of care applying to mental health services must also apply for those health services in immigration detention

*ii)* he mental health needs of those in immigration detention for longer than six months be routinely assessed by independent experts, and if indicated they be removed to appropriate treatment facilities

**l. The adequacy of education in de-stigmatising mental illness and disorders and in providing support service information to people affected by mental illness and their families and carers;**

- Tackling the stigma of mental illness, and of help-seeking

  Research has shown that one of the barriers to service use is the stigma associated with mental illness (Commonwealth Department of Health and Aged Care, 2000a).

  SPA believes that there is a need to tackle the stigma against mental illness as a barrier to recognition of symptoms and to help-seeking, and also to de-stigmatise help-seeking in relation to mental health problems, and depression in particular.

  Strong research evidence suggests that depression is the most common risk factor for suicide. Depression is a clinically significant factor in more than half of all suicides. Yet many individuals with depression are unrecognised, not treated or under treated (Lonnqvist, 2000). This is especially important in relation to the suicide of people who have received no diagnosis or treatment, but whom psychological autopsies reveal as probably having an affective disorder.

  Outcome 2.4 of the *LIFE* framework aims to increase the acceptability of help-seeking to respond to mental health problems and other issues. The NSPS is currently funding 11 local projects in this outcome area (NACSP, 2004). In addition the Commonwealth's *Mindframe* Strategy involves working with the media to improve reporting of suicide and to enhance community mental health literacy. Mindframe initiatives include, among other things, resources for media professionals and resources for community action against stigma.

  While some evaluation has been conducted of the efficacy of Mindframe promotional activities with media professionals, SPA considers that further investigation is needed to determine the impact of Mindframe on community mental health literacy.

  Outcome 1.3 of 'LIFE', the National Suicide Prevention Strategy, is to increase community acceptance and support for marginalised groups, people with risk factors for suicide and those affected by suicide. Under the NSPS there are currently eight local projects funded in this area.

  SPA acknowledges that under the NSPS significant attention has already been afforded to reducing the stigma associated with mental illness. Given that the de-stigmatising of depression and treatment for depression is a priority for suicide prevention, SPA considers there is a need for evaluation of current public education campaigns that focus on reducing the stigma associated with mental illness to determine their impacts on community attitudes.

**SPA further considers there is a continued need to develop innovative programs addressing:**

- Public education regarding depression;
- Improved recognition of depression;
- Enhanced treatment and management;
- Improved compliance with treatment regime; and
- Recognition of depression as a chronic condition demanding long-term management.

- There is a need for regulation of media reporting of suicide and related events

There is no explicit reference to the media in the Committee's TOR.

However, media presentations of suicide can increase suicidal behaviour in at risk individuals (Commonwealth Department of Health and Aged Care, 2000b). A review of the association between media portrayal of suicide and suicidal behaviour found evidence of a causal association between media portrayal of suicide and actual suicide in the case of non-fictional presentations of suicide in books, newspapers and on television (Pirkis & Blood, 2001).

As previously mentioned, significant gains have already been made regarding media reporting of suicide under the national initiative *Mindframe.* The publication, *Reporting suicide and mental illness – a resource for media professionals*, has been developed and widely distributed to media organisations. A recent evaluation indicated that familiarity with the Mindframe resources is approaching 50 per cent. Furthermore, negotiations have commenced with large media organisations to include Mindframe resources in their internal training programs and Codes of Practice (NACSP, 2004).

**SPA commends the progress in this area to date and considers that further evaluation is required to determine the extent of compliance with existing media guidelines and actions that may be undertaken to enhance compliance with guidelines. Specifically, there is a need to:**

- Implement, re-present, maintain and promote adherence to existing media guidelines;
- Ensure that reports of suicide do not detail the method or location;
- Ensure that telephone numbers for help lines and counselling services are provided in media reports of suicide;
- Ensure that only newsworthy suicides are reported, and that suicides of well known individuals are reported as deaths not as suicides where possible; and
- Ensure that the causes of suicide are emphasised in media reports.

SPA further considers there is a need to promote the development of positive roles of the media in suicide prevention. In particular, the media can play a health promotion role for people with psychosocial and mental health problems and can portray situations of positive coping.

**n. the current state of mental health research, the adequacy of its funding and the extent to which best practice is disseminated;**

**&**

**o. the adequacy of data collection, outcome measures and quality control for monitoring and evaluating mental health services at all levels of government and opportunities to link funding with compliance with national standards;**

Action area 6 in LIFE is titled, 'Progressing the evidence base for suicide prevention and good practice'. The aim of this *action* area is to ensure that programs have the greatest chance of benefit and minimum risk of harm by building the evidence base, sharing good practice and providing education and training.

The following recommendations are relevant to this sixth action area:

- Priority needs to be given to funding of suicide research and suicide prevention research
- There is a need to conduct research and evaluation of psychiatric hospital services
- Planning and funding processes for projects that are part of major strategic initiatives should be built around clear, centralised evaluation protocols
- There is a need to provide adequate centralised support for project managers, project staff and local evaluators in evaluation planning, data collection, data analysis and reporting
- Closer collaboration is needed between service providers, policy makers, community leaders, consumers and academic evaluation researchers
- There is a need to ensure that findings from evaluation are used in service and program planning at the national, state and local levels
- Priority needs to be given to funding of suicide prevention research
- The capacity of the suicide prevention research community needs to be enhanced
- The first person, lived experience of suicidality is a research priority in order to bring the expertise of those who know suicidality 'from the inside' into the discipline
- There is a need to enhance the scientific knowledge base regarding effective interventions
- There is a need to investigate and evaluate specific interventions

- 1) Priority needs to be given to funding of suicide and suicide prevention research

Funding limitations and funding mechanisms challenge robust research. While SPA acknowledges that the Australian Government commits approximately $10 million dollars annually (until June 2006) under the NSPS to suicide prevention, there is also a need for key granting bodies (e.g. NHMRC) and government departments to give priority to the funding of suicide and suicide prevention research.

In particular, there is an outstanding dearth of information about risk and protective factors for suicide and suicide attempts in the Australian population. Although Australia has its own unique demography, landscapes and social programs, most Australian suicide prevention projects rely on overseas data for information about risk and protective factors.

SPA recommends that:

That funding be allocated for a comprehensive national review of all suicides for an adequate time period (e.g. three years), to determine individual, social and service-related factors relevant to suicide in Australia, and with a particular view to identifying modifiable, systemic risk factors.

- 2) There is a need to conduct research and evaluation of psychiatric hospital services

Psychiatric patients are at increased risk for suicide at the time of inpatient admission and the period following discharge from inpatient care. The implication for services is that improved integration of inpatient and community-based care would reduce risk at these critical transitions (Appleby, 2000).

To address this issue, SPA considers there is a need to:

- Evaluate, at a national level, suicide deaths by inpatients in order to determine the extent of the problem, potentially modifiable risk factors and evaluate interventions; and
- Evaluate, at a national level, death by suicide (and suicide attempt) following discharge from psychiatric hospital in order to determine potentially modifiable risk factors and evaluate interventions.

- 3) Planning and funding processes for projects that are part of major strategic initiatives should be built around clear, centralised evaluation protocols

Clear evaluation protocols are important to ensure that as much as possible is learnt from research projects and initiatives. All programs under the NSPS should be evaluated.

Outcome 6.1 of *LIFE* is to support strategic research and evaluation of programs, ongoing and longitudinal research, and the dissemination of knowledge gained to facilitate good practice. Several of the strategies listed to achieve this outcome relate to the need for evaluation resources The NSPS currently funds nine local projects in this area.

Work on evaluation is currently occurring at several levels under the NSPS. In 2001, the manual *Evaluation: A guide for good practice* was developed and disseminated to all NSPS projects. Following this, the *Manual to Guide the Development of Local Evaluation Plans* was developed to assist evaluation of

projects. All national projects have evaluation strategies in place and evaluation is also being undertaken across local level projects.

SPA considers that independent investigation is needed to determine the extent to which organisations currently use the evaluation manuals and find the manuals to be informative. There is also a need to explore ways in which to ensure that all NSPS funded projects incorporate an evaluation component.

- 4) There is a need to provide adequate centralised support for project managers, project staff and local evaluators in evaluation planning, data collection, data analysis and reporting

  Support for staff in research and evaluation planning is essential for building capacity, ensuring that data are of sufficient quality and quantity to answer strategic questions and continuing to build the evidence base for suicide prevention.
  As mentioned above, work on evaluation is currently occurring at several levels under the NSPS. SPA considers that in addition to work currently underway, project staff should be encouraged to develop ongoing relationships with tertiary institutions with expertise in evaluation methods. State and Territory jurisdictions may also be able to assist in the project implementation stage in terms of advising on and supporting evaluation (NACSP, 2004).

- 5) Closer collaboration is needed between service providers, policy makers, community leaders, consumers and academic evaluation researchers

  Such collaboration is required to assist in the integration of evaluation research more fully into routine practice and program and service development. It is also essential to ensure that the data collected are useful for a wider range of purposes.

  While SPA acknowledges the research and evaluation work that has been conducted to date under the NSPS, it is considered that there is scope for more to be achieved in this area. In particular, SPA considers that the LIFE framework should be broadened to include a focus on collaboration between service providers, policy makers, community leaders, consumers and evaluation researchers.

- 6) There is a need to ensure that findings from evaluation are used in service and program planning at the national, state and local levels

  There is still a challenge to ensure that organisations recognise the importance of disseminating learnings from evaluations (NACSP, 2004).

  Some projects have been proactive and developed a learning loop so that data being generated through ongoing evaluation can be used to improve the operation of their program and its outcomes (NACSP, 2004).

While acknowledging some achievement in this area, SPA considers that further efforts are required to ensure use of evaluation findings in service and program planning. Some ways in which to achieve this are to:

- Support dissemination of results in a variety of formats;
- Ensure that planning has an adequate timeframe; and
- Involve evaluation researchers in planning processes.

- 7) The capacity of the suicide prevention research community needs to be enhanced

SPA considers that there is a need to improve the capacity of the suicide prevention research community. This could be achieved through:

- Training;
- Support;
- Security of tenure;
- Career pathways; and
- Collaboration.

- 8) The first person, lived experience of suicidality is a research priority in order to bring the expertise of those who know suicidality 'from the inside' into the discipline (this is also applicable to TOR i)

There is currently little attention afforded to what suicidal thoughts, feelings and behaviour actually means to those who live these experiences. Such knowledge is considered essential to any attempt to understand and explain suicidality, which in turn is necessary to inform and test theories and models of suicidality, including intervention and prevention strategies.

SPA considers that there has been particularly little research into the pathways to recovery from suicidality from the first person perspective, that is, of what has and has not worked form the consumer-survivor perspective.

SPA further considers that meaningful, ongoing inclusion of consumer-survivors and their organisations is vital in all areas of suicide prevention including, but not limited to, the research agenda.

In order to promote and develop the inclusion of consumer-survivors as active participants in research, SPA recommends that the LIFE framework is broadened to recognise and support mental health consumers and their organisations in the development of their own research capacity, research agenda and research projects unconstrained by the agendas and needs of other research programs.

Such a research agenda could be developed through the promotion of an expanded nationwide network of networks of mental health consumer organisations, run by and for consumers, where consumer-survivors can meet and collaborate with other researchers in suicide prevention.

- 9) There is a need to enhance the scientific knowledge base regarding effective

interventions

The scientific knowledge base regarding effective interventions is relatively poorly developed. SPA considers there is a need for research to identify:

- Programs that are effective;
- Programs that are not effective;
- Programs that appear promising; and
- What is not yet known.

This research would provide a body of knowledge that would allow policymakers and funders to fund programs that are effective and that appear promising, and not fund programs that are ineffective.

SPA therefore considers that there is a need for funders to:

- Demand scientifically rigorous evaluations;
- Demand outcome evaluations;
- Fund long-term evaluations;
- Train a workforce capable of implementing programs effectively and evaluating them rigorously; and
- Create a resource inventory of effective programs.

- 10) There is a need to investigate and evaluate specific interventions

  SPA considers there is a need for researchers and clinicians to implement randomised controlled trials (and other designs) to investigate specific interventions to:

  - Reduce repetition of deliberate self-harm; and
  - Reduce death by suicide.

**p. The potential for new modes of delivery of health care, including e-technology.**

Furthering initiatives that promote and prevent mental health

The Terms of Reference do not specifically mention prevention programs as a mental health strategy, except in relation to primary health care. However, the Senate Select Committee without doubt will have such programs within its sights. Australia has been particularly innovative in this area, which is a new, cost-effective mode of health care delivery. Yet for maximum impact and outcomes such programs require further support, development and evaluation in the next few years.

For example, Action Area 1 of 'LIFE', the National Suicide Prevention Strategy, is 'Promoting well-being, resilience and community capacity across Australia'. The aim of this action area is to enhance protection against suicide by enhancing well-being, optimism, connectedness,

resilience, health and capacity across the entire community, with a particular focus on young people and their families. SPA has two specific concerns relevant to this area.

1. There is a need to promote the development of more effective coping mechanisms, especially among young people.

This recommendation relates to promoting the need to develop, through mentally healthy schools, improved self-esteem, the development of creative options, positive life values and the need for inclusiveness and mutual respect in society. It also relates to the need to explore programs that promote creative problem solving in young children.

Research has shown that many young people commit suicide in response to stressful life events (NSW Commission for Children & Young People, 2003). This suggests that young people need to be equipped with the coping and problem solving skills required to manage stressful situations and cope with emotional disappointments.

Outcome 1.1 of *LIFE* aims to increase community capacity and emotional well-being across Australia. Considerable progress has already been made by the NSPS in this area. For example, *MindMatters*, Mindframe (the Media and Mental Health Strategy), CommunityLIFE, Auseinet, Response*ability* and Lifeline Australia's Information and Referral database, *Just Look*, are creating resources and environments for promoting mental health and well-being in the majority of the population who generally do not experience emotional difficulty (NACSP, 2004).

Evaluations of some of these initiatives are showing promising effects. For example, the independent evaluation of *MindMatters* is showing that some schools are attributing their involvement with the initiative to improvements in retention rates, truancy, suspensions and staff-student relationships (NACSP, 2004).

SPA commends the accomplishments to date and considers that further evaluation is critical for the ongoing success of initiatives in this area. In particular, evaluation is required to determine the extent to which school-based mental health promotion programs enhance students':

- Self-esteem;
- Problem-solving skills;
- Ability to cope with stress;
- Awareness of mental health problems;
- Help seeking behaviour; and
- Helping behaviour towards others.

2. There is a need to recognise the importance of confidentiality to young people

Confidentiality is paramount to young people. Research shows that young people do not like to discuss problems with teachers or school counsellors as they do not believe that confidentiality will be maintained (NSW Commission for Children and Young People, 2002).

Teachers and counsellors are often the first line of support for young people. Given that young people do not have sufficient confidence in their teachers and counsellors, SPA considers there is a need for the *LIFE* framework and other national mental health programs to be broadened to include a focus on education and training for teachers in these issues.

3. There is a need to reduce access to suicide methods

Evidence suggests that reducing the accessibility of more lethal methods of suicide can reduce suicide rates for that method and overall (Commonwealth Department of Health and Aged Care, 2000b). For example, reductions in the suicide rate among Australian women have resulted from reduced access to barbiturates (Cantor et al., 1996; cited in Commonwealth Department of Health and Aged Care, 2000b).

Outcome 2.6 of LIFE aims to reduce access to identified lethal methods of suicide. Some of the strategies listed to achieve this include encouraging the safe storage and use of firearms, the erection of barriers on potential jumping points and limiting pack sizes of potentially lethal medications.

A national initiative under the NSPS aims to reduce the overall suicide rate by making motor vehicle exhaust gas suicide substantially more difficult to undertake and complete.

While significant gains have been made in this area, SPA considers there is a need for independent research to determine the extent to which the current strategies to reduce access to lethal methods of suicide are effective.

**Where to from here**

A review of the *LIFE* Framework is to be undertaken by Auseinet, and will involve a series of community consultations. SPA urges that this review incorporate the recommendations put forward by the SPA conference delegates.

SPA also recommends that:

1. The Australian Government incorporates the recommendations from this document into the review of the National Suicide Prevention Strategy and the National Mental Health Strategy; and
2. The State and Territory Governments review and update their suicide prevention strategies to reflect the recommendations from this document.

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