Submission to the Senate Community Affairs Committee

Inquiry into Suicide in Australia

11 December 2009

Foreword

"His suicide was tragic, made all the more so because it was preventable, we believe, but for the inadequacy of the public mental health system. [X] died just two weeks after his first suicide attempt, eight days after his discharge from the Canberra Hospital psychiatric unit, two days after being refused admission to the psychiatric [unit] following a second suicide attempt, and within hours of contact with the mental health crisis team. On the day of his death, [X] had contact with the mental health system no less than three times."

(Anonymous, Australian Capital Territory, Submission #288, Not For Service 2005)

Executive Summary

The Terms of Reference for the Senate Inquiry into Suicide in Australia focus on the impact of suicide on the Australian community, including high risk groups, such as Indigenous youth and rural communities, and the effectiveness of the current national strategy and programs.

This submission has been prepared with a focus on these three key areas plus the vital matter of accountability for the system overall.

The Mental Health Council of Australia (MHCA) has already contributed to the Joint Submission, *Suicide is Preventable,* prepared by a group of leading national organisations involved in every aspect of suicide prevention, including Lifeline Australia, Suicide Prevention Australia, The Inspire Foundation, OzHelp Foundation, The Mental Health Council of Australia, The Salvation Army, the Brain and Mind Research Institute, and the University of Sydney.

This submission should be read in conjunction with *Suicide is Preventable* to gain the full perspective of our recommendations and those of our members.

The MHCA commends the Senate for acknowledging this very important issue through the conduct of this inquiry into suicide in Australia. The problem of suicide cannot be overstated and it affects every Australian in some way.

The MHCA recognises that suicide is not entirely a mental health issue, however almost all suicides are related to issues affecting mental health, well-being and social inclusion. The MHCA has identified three key areas where governments should take decisive action to reduce suicide and suicide attempts in Australia. These areas include a number of recommendations that are supported by Australian and international research, as referenced in this submission. The issues contained in this submission, in addition to those already raised in *Suicide is Preventable*, represent the key priority areas for immediate action identified by the sixty national member organisations which make up the MHCA.

A distinguishing feature of suicide and mental illness is social isolation. It is commonplace for a person to be discharged from a mental health service following an attempted suicide and disappear into the community, without any arrangements for follow-up care in the community. This represents a fundamental breakdown in our mental health service and is a breach of our collective duty of care.

There is an urgent need to construct a new and effective community-based care model of service specifically in relation to suicide. This model would be open-ended and, in essence, create a 'no wrong door' approach to reducing suicide and suicide attempts, especially amongst high-risk groups. This new community-based care model would resemble a hub of primary care services (clinical and non-clinical) with spokes of specialists (clinical and non-clinical) reaching out to areas of high-risk and need. The current system is best characterised as almost universally fragmented. A feature of a new approach to community care must include synchronised services incorporating community development, youth outreach, community nursing and General Practice in the one package.

A holistic community care model would also encompass postvention and post-discharge services, including compulsory follow-up and linking suicidal persons with the most appropriate services, treatment or support networks. The available literature provides clear evidence that postvention is an effective method of preventing a suicidal person from subsequent attempts.

> **Recommendation 1:** *The development of an inter-sectoral community-based best-practice model focusing on synchronising services so that individuals who need support will receive the most appropriate care either directly or by being properly re-directed to an appropriate service. As part of this model, governance issues need to be given due consideration and addressed in consultation with the community receiving the services.*

> **Recommendation 2:** *Investment in providing evidence-based appropriate post-discharge care to those who have attempted suicide, ensuring that individuals are provided with an active follow-up plan and support upon discharge from any hospital or acute mental health service. Specifically, any follow-plans need to be delivered by the most appropriate services, which will most likely be relevant community-based services.*

The second key area necessitating urgent government action is accountability. It is apparent that past and current approaches to suicide prevention have failed to reduce the tragically high rate of suicide in Australia. The lack of accurate data on suicide and suicide attempts means that governments (and service providers) are not able to identify the size of the problem and are therefore unable to provide the appropriate resources and responses.

There is a critical need for sustained investment in transparent, independent and more sophisticated processes of data collection, including the way coroners record suicides. Further, the collection of accurate and objective data must be matched with a commitment to deliver accountability of service providers and government programs. Unless measures are put in place to ensure that programs and policies are working, we will continue to see precious resources going to antiquated systems and failed programs; programs that have failed for many years to make significant inroads in reducing suicide rates, especially in high-risk groups and communities.

Robust accountability and transparency means removing the process whereby governments assess their own performances and measures, and giving this role to organisations that can provide genuine oversight and accountability of progress in reducing suicide in Australia.

> **Recommendation 3:** *That investment is made to enable the independent, transparent capture of data to inform decision-makers and the general community about progress in addressing suicide. Key data elements would combine as part of a Suicide Accountability Framework that involves regular public reporting, and that enables increased public understanding and diminishes stigma.*
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> **Recommendation 4:** *The Australian Government must significantly increase funding for suicide prevention services, ensuring that these services can increase their capacity to document their practice, to fill existing knowledge gaps, and to ensure that the most useful and relevant information is available to those who work in suicide prevention.*

The third key area involves greater engagement with at-risk groups, and in particular Indigenous Australians. Indigenous youth are the most 'at-risk' group in Australia. Indigenous funding programs need to be greater in scope and duration to enable real changes. Current bureaucratic approaches to Indigenous communities are simply not effective, and greater flexibility is required, including community consultation and bottom-up approaches. There are models that appear to be working, and these must be adopted nationwide wherever appropriate (only after consultation with the relevant communities).

In line with greater accountability, there is a case for conducting Indigenous Suicide Response Workshops nationally in order to ascertain an accurate picture of what Aboriginal communities see as the problem about why *their* youth suicide is so high and what can be done about it. We need to understand the issues from their perspective and not see suicide prevention strategies as a 'one-size-fits-all' policy approach.

Employment and community development is another key element in reducing Indigenous suicide. The MHCA recommends adopting and/or pursuing initiatives that deliver not just paid employment, but measures which increase resilience, thereby reducing hopelessness, alienation and social exclusion.

> **Recommendation 5:** *The Australian Government must significantly increase funding for research and suicide prevention services, specifically for at-risk populations. These should including community education and social marketing programs aimed at eliminating stigma towards at-risk populations and also within these populations regarding mental illness, care-seeking and recovery.*

> **Recommendation 6:** *The Australian Government should invest in the development of a series of Indigenous Suicide Response Workshops to gain an accurate picture of what Aboriginal communities see as the problem, and to develop possible solutions to inform future Indigenous specific suicide prevention strategies, particularly amongst Indigenous youth.*

Background

A lot of crisis services are now based in emergency departments at nights and on weekends. They are doing much less outreach and they are losing that culture of visiting people in their homes and helping people with their crises in their homes. When you present at an emergency department, you tend to present with a lot more clinical symptoms. When you present and get an evaluation at home, you tend to present with more life problems between people. We are losing the ability to see the life problems as well as the high salience clinical issues.

(Professor Alan Rosen, Secretary, Comprehensive Area Service Psychiatrists Network, From Crisis to Community, Senate Report into Mental Health, Hansard, 3 August 2006).

Every year, almost one million people die from suicide worldwide. The estimated global mortality rate is 16 per 100,000 although this is only an indication as many nations do not record these statistics and the means of recording such data is extremely varied and inconsistent. From the data that is collected, it is clear that suicide rates have increased by 60% over the last 45 years, with suicide as the leading cause of death in the 10-24 years age group. As concerning as this is, it is important to note that the rates of attempted suicide are thought to be 20 times higher than the suicide rates. Risk factors for suicide differ according to the nation, however it is widely accepted that there are a complex range of psychological, social, biological, cultural and environmental factors which combine in various ways to increase the likelihood that a person will suicide (WHO, 2009).

Suicide accounts for 1.3% of all deaths in Australia, which means that there are between 6 and 7 suicides every day. The most recently released ABS data (2009) revealed that there were 1,881 suicides in Australia during 2007, with this being the leading cause of death among people under 34 years of age. As with the world figures, rates of people who attempt suicide are believed to be between 10 and 20 times higher than the suicide rate (ABS, 2008).

Of course it should be noted that the number of suicides is believed to be much higher than this due to issues around quality of data and inconsistent coronial practices (ABS 2008). The actual rate is widely believed to be as much as 30-40% higher than the recorded figures.

As per the World Health Organization (WHO) findings, Australia-specific research has found that suicide is an event with multiple interacting factors that can be complex in nature. One of the most common and significant contributing factors is mental illness, with the recent ABS National Survey of Mental Health and Wellbeing revealing that people with a mental illness are much more likely to have serious suicidal thoughts than other people (8.3% compared to less than 1%). This is consistent with other Australian research which indicates

that about 65% of people who die by suicide have symptoms consistent with major depression at the time of death.

**Map of suicide rates (per 100,000 most recent years available as of 2009)**
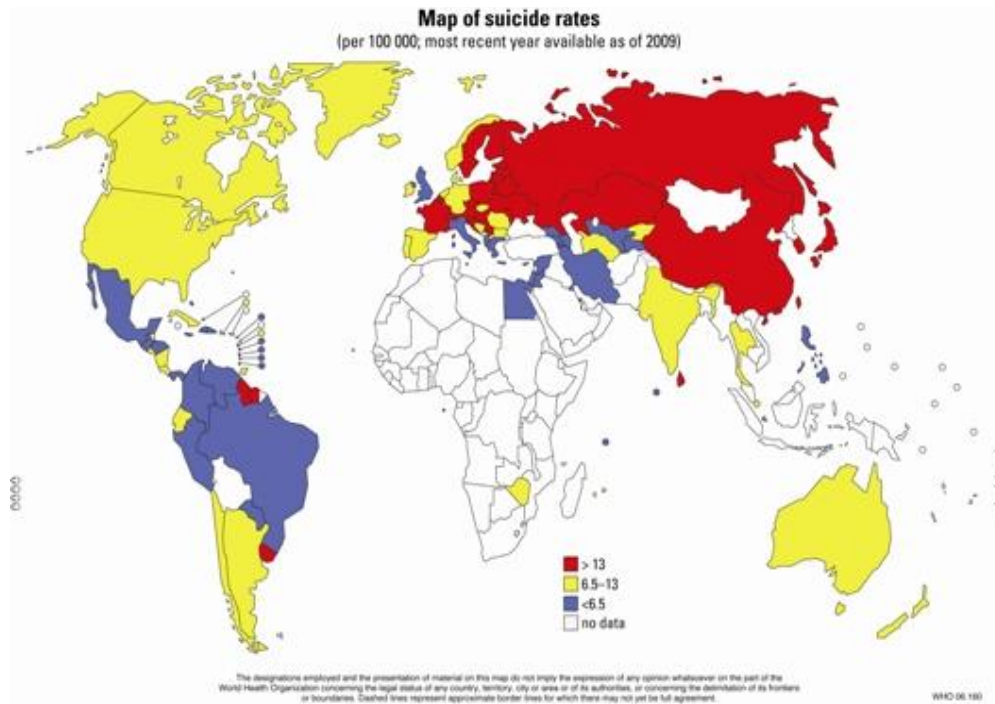
Source: WHO, 2009

When discussing effective interventions, the WHO (2009) emphasises the need for a multi-sectoral approach involving many levels of intervention and activities. They highlight the need for adequate prevention and treatment of depression and alcohol and substance abuse disorders as a way of reducing suicide as well as ensuring appropriate follow-up contact for those who have attempted suicide.

These interventions will only be effective if a number of currently existing problems are addressed. This includes accurate and standardised investigation and reporting methods; measurements to assess and monitor the value of any prevention, intervention and postvention programs; and a stated minimum level of accountability across government and non-government organisations.

Age-standardised suicide rate per 100,000 population across Australia by ABS statistical subdivisions (2001-2004)
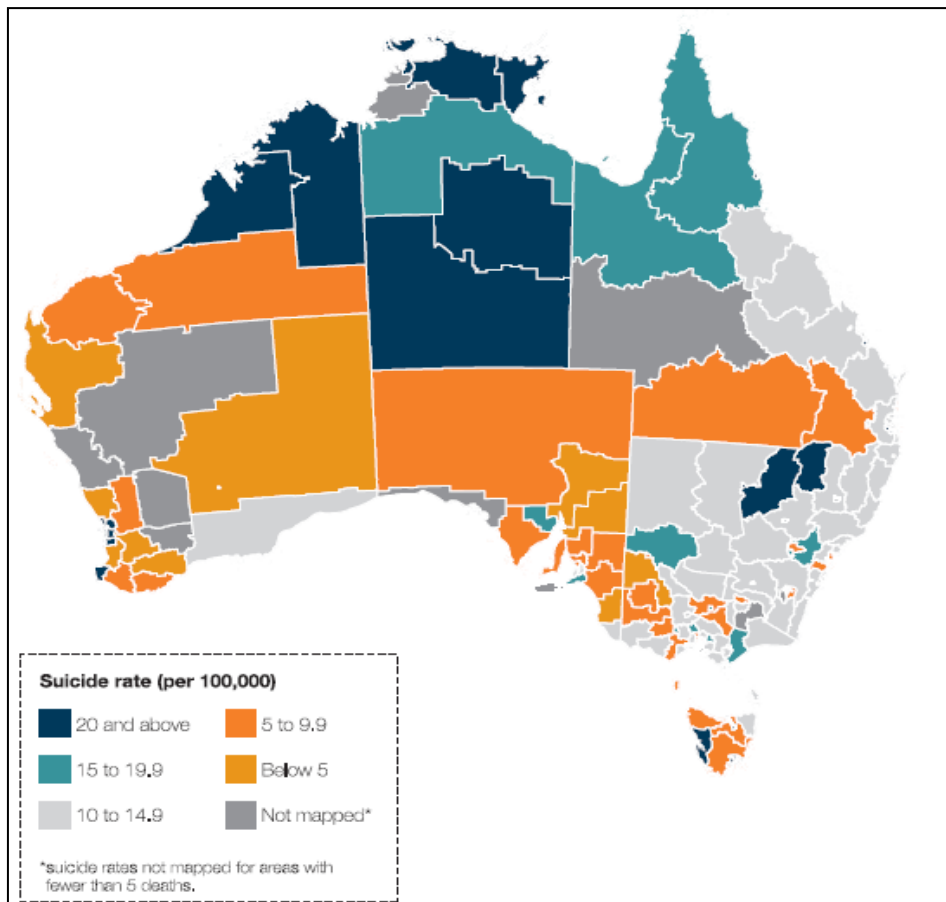
Source: Department of Health and Ageing, 2008

A New Model for Community Mental Health Care

"[X] completed suicide ... 10 hours after being discharged from the ... Psychiatric Unit. He made 2 suicide attempts prior to admission ... the coroner stated "It seems clear to me that staff were over anxious to discharge [X] due to the perennial shortage of beds ... and that this is one of many cases which highlight Government neglect in the area of mental health facilities. Many promises are made but many do not eventuate or are delayed excessively. This is causing needless deaths in the community ... the public are entitled to expect that the mentally ill will be properly cared for by government funded services ... [X] was discharged with a minimum of formality and no guidance or assistance ..."

(The coroner's report in Carers, parents, New South Wales, Submission #137, Not for Service, 2005)

The MHCA recommends that a new model of community mental health care is required to tackle the extremely complex problem of suicide. There is never going to be one single intervention to prevent this tragic loss of life. A multi-tiered inter-sectoral approach is required so that individuals who need support will receive the most appropriate care either directly or by being properly redirected to an appropriate service. Presently there is a serious disconnect between services leaving individuals without the proper care necessary to prevent a subsequent suicide attempt. Isolation is the enemy of good mental health and our current system of care perpetuates rather than minimises isolation.

Directing suicidal persons towards a GP is not the sole answer. There needs to be a number of urban and regionally located community care centres that offer relevant synchronised services that are suitable for persons at-risk as well as those who are at high-risk of suicide. There is a need for effective referral systems and mechanisms that ensure people are not falling through the service gaps. This is especially the case for hard-to-reach populations (e.g. Indigenous and culturally and linguistically diverse) who may be less likely to interface directly with a generic health service, but will prefer to see a local community organisation. Similarly, services such as those dealing with homeless individuals may encounter at-risk individuals.

One overseas example of an exemplary suicide prevention strategy is the *Choose Life* National Strategy and Action Plan adopted in Scotland. This plan aims to reduce suicide and to improve the mental health and wellbeing of the local population. To achieve these aims, the strategy embraces a long-term vision based on shifting attitudes and strengthening capacity and commitment in communities and in mainstream services.

A recent evaluation of the Scottish model highlights that community capacity building can only be achieved by reducing stigma associated with suicide and mental health problems more generally, and by raising awareness among the general public about when and how to seek, and give, help and support (Platt et al., 2006). Importantly, this example also

demonstrates that suicide prevention strategies will only work if they are integrated with other mental health promotion frameworks.

The MHCA recommends that any new models include a combination of clinical and non-clinical services, localised to specific community needs. At the very least, this cluster of services should include community development, youth outreach, community nursing as well as primary health services. Where there are high sub-population groups, local services need to accommodate the specific needs, values and culture of the individuals seeking these services.

The Innovative Health Services for Homeless Youth is an example of a model that included these elements, and incorporated Indigenous specific services. Another example is the Headspace model, which provides many linked services through the one hub. However, the fact that it operates as fee-for-service may limit its uptake amongst those who are most in need.

It is not within the scope of this submission to comprehensively review specific models. However, it should be noted that there are a number of effective models in place which need to be carefully reviewed and considered when developing new or alternative styles of service provision.

The way to achieve the 'ideal' model for each community is through consultation with those communities to establish exactly what is needed. Secondly, the communities should feel some ownership of these models of care, including being involved in the governance component, rather than left solely with the clinicians.

Postvention / post-discharge / bereavement

It is estimated that more than 170 people *attempt* suicide every day in Australia and, for every suicide death, 8-25 attempts occur. Previous suicidal behaviour increases the risk of an individual attempting suicide later. Attempting suicide overcomes an individual's instinct of self-preservation, which means that one of the best predictors of a future suicide attempt is a previous one.

Research suggests that people who have recently been discharged from hospital after treatment for mental illness may be at higher risk of suicide. According to a number of international studies, an individual receiving inpatient psychiatric care is at the highest risk of suicide during the inpatient and post-discharge periods (Meehan et al., 2006; Goldacre et al., 1993; Geddes & Juszczak, 1995; Appleby et al., 2001; Yim et al., 2004).

A number of studies have calculated the rates of suicide within 28 days of discharge at between 2.9 and 4.3 suicide deaths per 1,000 discharges (NSW Mental Health Sentinel Events Review Committee, 2005; Appleby, 2000). Meehan et al (2008) went further,

suggesting that the first week and even the first day following discharge was a particularly high-risk period for the individual.

There needs to be a compulsory follow-up plan for people discharged from hospital or other services after attempting suicide. There is currently no requirement upon hospital and frontline staff to ensure that individuals at high-risk of suicide are given the necessary follow up care and ongoing case-management.

There have been a number of Australian and international studies demonstrating the positive effect that appropriate follow up can have with those who have attempted suicide (Robinson et al., 2008; Stark et al., 200; Motto & Bostrom 2001; Page et al., 2007).

A recent Australian study illustrates the effectiveness of follow-up case-management and regular telephone calls undertaken over a twelve-month period. This study found that, amongst the 120 male research participants who had attempted suicide and received follow-up care, there was improved mental health status, decreased suicidality, increased help-seeking behaviours and social functioning, in addition to improved satisfaction of the health care system (Robinson et al., 2008).

These findings are consistent with those found by Fleischmann and colleagues (2008) who found that that a low-cost brief intervention among those who have previously attempted suicide could play an important part in suicide prevention programs. This study involved a brief intervention as well as contact in which people were provided with education and follow-up and was conducted with nearly 2000 people who had attempted suicide, across five countries.

Another postvention study conducted in the United States examined whether long-term professional contact with persons at-risk of suicide can exert a preventative influence. The study was specifically targeted towards high-risk individuals who refused to remain in the health care system. A total of 843 people who refused any ongoing care were randomly assigned to either an experimental or control group. The control group received no further contact, while the experimental group were contacted by letter at least four times a year for five years. People in the experimental group had a significantly lower rate of suicide in the first two years when compared to the control group. After this period the disparity in suicide rates between the two groups lessened with each year. The conclusion was that a systematic program of contact with individuals at risk of suicide appears to have a significant preventive influence for at least two years (Motto & Bostrom, 2001).

A similar postvention study conducted in Newcastle, Australia, examined whether an intervention using postcards would reduce the incidence of hospital treated deliberate self-poisoning. Utilising a regional referral service, 772 people who had been previously treated for self-poisoning were randomly assigned to an experimental or control group. The

experimental group were sent eight postcards over 12 months, while the control group were not. The study found that a postcard intervention reduced repetitions of deliberate self-poisoning, although it did not significantly reduce the proportion of individuals attempted suicide again (Page et al., 2007).

A quarter of all suicide attempts occur in young people between the ages of 15 and 24 years, with young women particularly at-risk. Women are most likely to *attempt* suicide, whereas men are more likely to *die* by suicide. As a result, women are often viewed as 'attempters', while men are typically seen as 'completers' and are therefore considered to be at a higher risk then women. It is important to note, however, that every suicide *attempt* is serious and warrants attention. Because men tend to choose more lethal means than women, it is more likely to result in a fatal outcome (Payne, Swami & Stanistreet, 2008; Cibis et al., 2009), however, this does not of itself make an *attempt* any less serious in the first instance.

Both of these groups are entering into a suicide with an intention to die, often due to a perception that they can no longer deal with an unbearable pain. In fact, a person who survives a suicide attempt is likely to face compounding problems on top of those that led to their decision to suicide in the first place. They are more likely to experience hopelessness and feelings of powerlessness, and are more inclined to use and/or abuse licit and illicit substances.

The WHO (2009) supports the evidence which suggests that self-help support groups can be a powerful and constructive means for people who have been bereaved by suicide. It has been shown that groups can work together to create significant positive outcomes for all involved. Research has shown that the elements of grief are greatly exacerbated in suicide survivors, who report that feelings of stigmatisation, shame and embarrassment set them apart from those who grieve a non-suicidal death. These issues can make it difficult for those bereaved by suicide to admit that the death of their loved one was by suicide.

A support group can provide those bereaved by suicide with an opportunity to be with other people who can really understand, due to their shared experience of losing someone to suicide (WHO, 2009). Support groups can provide a number of benefits including:

- a sense of community and support with an empathetic environment;
- a sense of belonging when the bereaved person feels disassociated from the rest of the world;
- the hope that "normality" can be reached eventually;
- experience in dealing with difficult anniversaries or special occasions;
- opportunities to learn new ways of approaching problems;
- a sounding board to discuss fears and concerns; and,

- a setting where free expression of grief is acceptable, confidentiality is observed, and compassion and non-judgemental attitudes prevail.

The critical point to be made from the research presented above is the importance of postvention, post-discharge and bereavement strategies. An individual who survives after a suicide attempt should always be treated seriously, as they were most likely trying to end their life and if not achieved on the first attempt, they will most likely do so again if appropriate intervention is not provided.

The MHCA strongly urges the government to implement evidence-based postvention strategies to minimise the likelihood that an individual who has already attempted suicide will go on to attempt again in the future.

There is enough evidence to demonstrate that an appropriate discharge follow-up care plan and management by appropriately trained staff can not only prevent future attempts, but assist in rebuilding the lives of people. In addition, support groups for the individual and family/friends may be able to provide an environment where individuals can reconnect, providing a place of contact for assistance into the future.

The SANE Mental Illness and Bereavement Project (SMIBP) was established in April 2007 in response to research which suggest that people bereaved by suicide are more likely to suicide themselves. The focus of this project is upon suicide prevention. However, it also aims to support the family and friends of a person who suicides or goes missing, recognising that this had been a largely unaddressed area of need. The project is now in its second phase, with a number of resources available to those needing help to deal with losing a loved one. This project has really filled a gap for those left behind and who previously found it difficult to locate resources specific to the situation that they were confronted with. This is an example of only a couple of currently existing programs being run specifically to assist families bereaved by suicide.

The MHCA recommends a substantial increase in the number of services addressing postvention and bereavement associated with suicide. The MHCA endorses those recommendations put forward in *Suicide is Preventable* in relation to postvention and bereavement, restating and reiterating their importance below.

Recommendation	Rationale
Recommendation 2.2 - Investment in stepped care services across Australia to minimise the likelihood of hospitalisation for mental illness and to ensure all consumers discharged from acute care have access to appropriate and effective support.	Persons with severe and persistent mental illness (SPMI) carry a significantly elevated risk for suicidal behaviours. Stepped care with active management of clients, has been shown to reduce suicide risk. All acute care mental health services have an obligation to people with SPMI, to provide safe transition of clients and are ideally positioned to lead suicide prevention efforts for this sub-population. Access to effective mental health services for people with SPMI can prevent substantial morbidity and mortality associated with fatal and non-fatal suicidal behaviours.
Recommendation 4.20 – The Australian Government should review the National Bereavement Strategy as a matter of urgency and actively promote and implement Australia's *National Suicide Bereavement Strategy* via a commitment to recurrent or long-term funding and improved transparency and coordination.	The *National Suicide Bereavement Strategy* was completed in 2006. It has never been released by DOHA and no explanation has been provided to stakeholders.
Recommendation 4.21 – The Australian Government should sponsor or develop evidence-based 'best practice' principles as the foundations for all suicide bereavement outreach services and postvention initiatives and promote quality assurance and training of bereavement support groups.	An array of programs has developed in recent years in postvention, often without access to a sound knowledge basis.
Recommendation 4.22 – Introduce formal mechanisms for the provision of information about support services available to families and friends bereaved by suicide, and provide a single point of contact for future assistance.	Presently families can be left without any advice or support following a suicide. In other cases, materials are received months after the death, giving rise to grief and anguish again. The prompt provision of evidence-based material and support will reduce the risk of suicide for bereaved persons.
Recommendation 4.8 – That discharge from an acute care mental health facility must require: an appropriate discharge plan, a warm-hand over of a consumer/client to a step down service provider, appropriate advice to enable family or carers to provide informed support for the consumer, and active follow-up from the acute care service within 7 days and again within 28 days of discharge.	Lapses in continuity of care, especially after discharge from emergency departments and inpatient psychiatry units, contribute to significant suicide-related morbidity and mortality.

Accountability & Research Priority Setting

There are a number of data and information problems in relation to suicide, and in this regard, suicide mirrors the mental health sector generally. There is an urgent need for sustained investment in new, transparent and independent processes to collect data on suicide.

The Fourth National Mental Health Plan states the following as key actions specifically in relation to addressing suicide:

- Provide education about mental health and suicide prevention to front line workers in emergency, welfare and associated sectors
- Coordinate state, territory and Commonwealth suicide prevention activities through a nationally agreed suicide prevention framework to improve efforts to identify people at risk of suicide and improve the effectiveness of services and support available to them.

The Plan does not specify how progress against these actions is to be assessed, but instead commits all governments to the development of a new system of accountability over the coming two years.

Seventeen years of mental health reform have failed to deliver the accountability required to provide funders, service providers, politicians and the general community with any confidence in our mental health system and our capacity to manage suicide. Efforts in this regard have been mostly directed by governments, in essence putting in place measures to assess their own performance. This fails the independence test. A robust system of accountability depends on independence and transparency and these must be the key features of a new effort to better understand suicide and its impact on the Australian community.

Emphasis needs to be placed on those measures which can assess the relationship between people affected by suicide and the broader health system, together with measures designed to give a picture of the real impact of services on the lives of people affected by suicide and their carers. There is therefore a requirement to assess the performance of mental health care using a mix of health, social and system indicators.

A basic indicator of the effectiveness of community mental health care, for example, is patient follow up in the community. Too often, patients are lost in the transition following discharge to the community. A responsive system would measure this and put in place appropriate communication and programs to promote continuity of care across service settings. Australia does not have systems in place currently to report on this indicator.

Similarly, data is not routinely collected on patient experiences or outcomes for services provided in primary care. Without this information, it is not possible to discern whether the

investment made has resulted in the key outcomes sought by people with a mental illness, reduction in symptoms, better health, return to study or work and so on. Some of the key markers of suicide-related mental health care accountability should include:

Key Markers of suicide-related mental health care accountability

1. Suicide rate
2. Death rates <3 and <12 months post discharge from a mental health facility, with cause of death
3. Level of place based follow-up in the community for people who access acute care
4. Mental health outcomes of people who receive care in primary care settings and in the community
5. Rates of general health assessment, including diet, exercise, dental health, level of alcohol, tobacco and other drug use by consumers
6. Delay before first treatment for psychosis
7. Consumer and carer perceptions of the care they have received
8. Number of persons accessing psycho-social rehabilitation programs
9. Employment outcomes - participation rates by people with mental illness in employment, education and training
10. Housing outcomes - the level to which people have been able to access and maintain stable housing options

The National Advisory Council on Mental Health has recommended a new set of national accountability measures for mental health in Australia. These measures are broader than suicide.

The MHCA supports the Joint Submission recommendation (3.2) that investment is made to enable the independent, transparent capture of data to inform decision-makers and the general community about our progress in addressing suicide. Key data elements would combine as part of a Suicide Accountability Framework to enable regular public reporting, contributing to increasing public understanding and diminishing stigma. In addition, it is imperative that systematic data collection incorporates a range of demographic variables, enabling specific at-risk groups to be identified, and to monitor progress in addressing areas of need. A list of the suggested measures to be collected as part of this framework appear in the table below.

Without these measures in place there is a very real danger that mental health service provision will continue to be outcome blind, often rewarding failure, and not responding to the needs of mental health consumers and their carers. A key role for this new system of accountability must be to build community confidence in Australia's mental health system.

Measures as part of a suicide related accountability framework

Data Item to be Collected	Rationale
Suicide Rate	Accurate and reliable data is critical to understand the scale of the problem and the impact of strategies designed to prevent suicide.
Death rates <3 and <12 months post discharge from a mental health facility, including cause of death	It is critical to know if a person is alive after interacting with the mental health system. Death may be from a range of causes, including the significant physical health issues that often affect a person with mental illness. This data will allow us to understand both trends in numbers and identify causes.
Percentage of the population receiving mental health care – both among general population and among population aged 12-25 years, specifically	With 75% of all mental illness manifesting before the age of 25 years, it is critical to monitor access to care among this population in particular, as well as among the general population.
Prevalence of mental illness	While a Household Survey on Drugs involving 25,000 households is carried out every three years, Australia waits a decade between surveys into the prevalence of mental illness. This is unacceptable.
Mental health outcomes of people who receive acute care, care in primary care settings and in the community	The Government is spending more money than ever before on primary mental health care – is this spending leading to better mental health outcomes for clients? The same questions need to be asked of care provided in acute settings.
Patient follow-up in the community	Many patients currently disappear from the health system following discharge from a service. This item would track the rate of follow-up care provided in the community, via GPs or through provision of psychological services or other care.
Rates of licit and illicit drug use that contribute to mental illness among young people	Alcohol and other substances are a key factor in many suicides and tracking their impact on young people is important for this reason.
Delay before first treatment for psychosis	There is considerable evidence to suggest that a rapid response to the emergence of psychosis is a vital ingredient in successful ongoing care.
Participation rates by people with a mental illness of working age in employment	Australia's employment participation rate for people with a mental illness is around half that of comparable OECD countries, at 29% (MHCA, 2007). This must be tracked to demonstrate the effectiveness of programs designed to increase participation.
Participation rates by people with mental illness aged 16-	Keeping younger people engaged in education and training is a key marker of social participation.

Data Item to be Collected	Rationale
30 years in education and training	
People with a mental illness reporting they have stable housing	The link between stable housing and good mental health has been understood for some time.
Community surveys of attitudes towards mental illness and suicide	It is important to track stigma and discrimination in the community, both generally and by specific target groups, such as employers etc. This data can inform health promotion activities.
Readmission rates to hospital < 28 days following discharge	This is a process measure, indicating the extent to which community services were available to a person discharged from hospital (N.B. there is conjecture in international literature about this as a valid indicator)
Re-presentation to emergency department < 28 days following discharge	Similar to the preceding marker, an indicator of the availability of services outside of hospital.
Percentage of involuntary admissions and involuntary community care compared to total admissions and total registered clients	An organised and supportive mental health system should see dependence on involuntary admissions reduce over time.
Waiting time for admission to a supported mental health place in the community	A marker designed to assess the availability of these key services.
Percentage of persons seen by a community-based health professional within seven days of discharge from a facility	A process measure indicating the connectedness of the mental health system as a person moves between service settings, to demonstrate some continuity of care.
Level of family assessment and support provided to carers	To better understand the risk factors for families and children of people with a mental illness.
National Mental Health Workforce Survey	In addition to monitoring the morale and wellbeing of mental health staff (across all services), this survey could also assess staff skills, etc in relation to suicide management and prevention.

The need to put these measures in place highlights the importance of setting informed priorities, rather than addressing suicide in the ad hoc manner that has been done in the past. Given the magnitude of the problem of suicide in Australia, it would be unrealistic to consider researching and addressing every problem at once. Policy-makers, planners and

practitioners need to be informed by a strategic priority-driven approach to suicide prevention research to ensure that most the useful and relevant information is available to those who work in the area of suicide prevention (Niner et al., 2009).

A recent study seeking to prioritise Australian suicide prevention sought the views of stakeholders who indicated that emphasis should be given to intervention studies and that *completed* suicide and *attempted* suicide are both issues warranting further work. They also recommended that a strategic approach to suicide prevention research will be important to fill gaps in knowledge to date (Robinson et al., 2008).

Finally, the recommendations raised in this section can only be achieved through continued discussions with relevant community and sector groups, to ensure relevance, reduced redundancy and efficient data collection systems. Accountability and data collection are issues that are pertinent to suicide research and prevention, as well as to mental health and health and human service systems generally.

At-risk Groups

Indigenous peoples

> *There are those complexities in our culture. It depends where that person is from. The same applies to a woman speaking with a male psychiatrist; she would not feel right. There were times when I had the whole extended family, including an aunty, an uncle and cousins, because they take it all on. It is not just a one on one with the psychiatrist, it is a very big family group, and they will have a family meeting about it. It is just that understanding that it is just not one person going through the mental illness; it actually involves the family, and therefore it ripples out into the community. It just depends on the person who walks through the door. You must be aware of that. Torres Strait Islanders are different from Aboriginals, and it depends where the community is from. Just because they are an Aboriginal does not mean that way of treating and therapy, or applying strategies for care or whatever will work for them as it does for somebody in Alice Springs, for instance.*
>
> (Ms Jenine Baily, Indigenous Researcher, Rural Health Research Unit, James Cook University, From Crisis to Community, Senate Report into Mental Health, *Hansard*, 5 August 2005).

Suicide was the leading cause of death from external causes for Indigenous males in Australia between 2001 and 2005. This rate was almost three times the rate of that for non-Indigenous males and close to four times the rate for the 0-24 years and 25-34 years age groups. This disparity was even greater for females, with suicide rates for Indigenous females five times that of non-Indigenous females (ABS, 2008).

It needs to be stressed that the rate of suicide within Aboriginal communities varies between locations and across time. In 2006, of the four states and territories with reported data, suicide accounted for 4.9% of all Indigenous deaths compared with 1.8% of deaths for non-Indigenous people. Appallingly, in 2006, 7.3% of deaths of Aboriginal people living in South Australia were due to suicide, compared to only 1.3% of non-Aboriginal people. In comparison, the Northern Territory showed much closer rates of 3.3% and 3% of deaths being determined as suicide for Indigenous and non-Indigenous people respectively (Auseinet - http://www.auseinet.com/files/factsheets/suicidestats_mar08.pdf).

Another example is that of Aboriginal males living in Western Australia, who had a dramatic increase in suicide rates from 4.7 per 100,000 in 1986 to 78.8 per 100,000 in 1999 (Telethon Institute for Child Health Research [TICHR], 2009). Further to this, the ABS data indicates that 47.3% of the Kimberley population are Indigenous, yet the suicide rate for this group is seven times higher than the non-Indigenous population (ABS, 2008).

In 2006, 24 young Indigenous people living in the Kimberly died as a result of suicide. This figure was an increase of more than 100% compared to previous years, and by contrast there were only three suicides by non-Indigenous persons with the same demographics (Hope, 2008). As a result of these deaths, an inquest was held reviewing the deaths of 22 young Aboriginal persons who had died between 2000 and 2007 in the Kimberley Region. The inquest was conducted by the current State Coroner, Alistair Hope.

At the conclusion of the inquest, Coroner Hope (2008) reported that:

It is clear that the living conditions for many Aboriginal people in the Kimberley are appallingly bad. The plight of the little children was especially pathetic and for many of these the future appears bleak. Many already suffer from foetal alcohol syndrome and unless major changes occur most will fail to obtain a basic education, most will never be employed and, from a medical perspective, they are likely to suffer poorer health and die younger than other Western Australian's. In this context the very high suicide rates for young Kimberley Aboriginal persons were readily explicable.

Hope (2008) concluded that although the Western Australian government had allocated $1.2 billion annually for Indigenous-specific programs and services, conditions for Indigenous people are actually worsening. He found that a major reason for the failure was due to the non-existent leadership by the government regarding the living conditions of Aboriginal people. He pointed out that no government agency had a lead role in addressing the terrible conditions and problems faced by Aboriginal people living in the Kimberley.

The reality has been that despite the disproportionately high rate of suicide by Indigenous Australians, intervention programs to address this issue at a whole of community level have not been forthcoming (Westermann, 2007).

This submission cannot provide the full scope of the problem of Indigenous suicide. However, contextually it is important to provide an overview of the issues confronting Indigenous people that may be different to the experiences of non-Indigenous people. This is necessary to ensure that the strategies employed to reduce the rate of Indigenous suicide are culturally relevant.

The trauma experienced by Aboriginal people through government policies of removing Aboriginal children from their families was aptly described as having had profoundly destructive and enduring impacts upon the social and emotional wellbeing of Aboriginal people (Silburn et al., 2006). The magnitude of this inter-generational trauma has significantly impacted Aboriginal communities, manifesting itself in perpetual cycles of drug and alcohol abuse, sexual abuse and incest, physical assault, homicide and significant health problems, which for some eventuate in the decision to suicide (Tatz, 2005). With the presence of this negative cycle of behaviours on such a large scale, the capacity of communities becomes diminished, limiting the chances of recovery and progress into more positive actions.

A number of bottom-up programs have been developed and run in communities with success. Unfortunately, much of the evidence pertaining to these is anecdotal so does not often appear in peer-reviewed journals. Some of those that have been measured and evaluated have been presented below.

- During the 1990s, there was a cluster of suicides in Yarrabah, Queensland, which local groups responded to by developing a number of empowerment strategies. The success of these strategies resulted in greatly reduced suicide rates within this small community. Following on from the Yarrabah project, the Centre for Rural and Remote Mental Health (2009) funded the *Building Bridges: Learning from the Experts* project which aimed to establish effective, sustainable, community-based approaches to building resilience, reducing suicide risk exposure and reducing self-harm.

  The project found that Aboriginal people view suicide as a consequence of a multitude of issues affecting residents at an individual, interpersonal and community level. Emotions such as stress, tension, unhealed grief, loss and anger have created a present in which people can be overwhelmed with conflict, pain and isolation. The project results demonstrated that knowledge sharing through both formal and informal means provided communities with much strengthened knowledge, skills and experienced (Centre for Rural and Remote Mental Health, 2009).

- Another example is that of The Balunu Healing Foundation, which runs a personal development program based in Darwin. The program runs a series of healing camps which aim to address the negative behaviours and consequent outcomes experienced by young Aboriginal people through the acknowledging the issues and challenges that they face. The aim is to provide support to Aboriginal youth, enabling them to make life decisions that will result in more positive opportunities for their future (Balunu Foundation, 2009).

- The program has recently been evaluated by the Menzies School of Health during 2008 and 2009. Of the 81 participants who attended the Balunu program over the past 16 months, including 60 males and 21 females, 78% of the males have previously attempted or thought about suicide and 70% of the females have previously attempted or thought about it. The evaluation found that the program brings about positive change for its youth participants (Cole, 2009).

- The Balunu program has been trialled in both the Darwin region and remotely and has been proven to be successful in both settings. This program identified that many youth have experienced either abuse or neglect that has adversely impacted their emotional and mental state of mind. All too often their anger and frustration is

converted into violence, crime, antisocial behaviour, and in many cases the only option left to escape their pain is suicide (Cole, 2009).

- The research indicates that the most successful projects are the ones that have been developed and implemented specifically by and for the communities they are intended for, aiming to foster empowerment. Where community members are involved in the programming and delivery of services, personal community and awareness have been shown to bring heightened (Eckermann et al., 1992) as well as increased levels of self-respect and dignity (Choo, 1990).

- Thompson (1996) showed that community involvement, consultation and control results in a higher level of commitment to achieving desired outcomes, improving sustainability and empowerment. Of particular note are the research findings that programs that connect young Indigenous people with their traditional culture and spirituality have been highlighted as important in suicide prevention (NACYSP, 1998).

- *Aboriginal Suicide is Different* (Tatz, 2005) focuses on the importance of communities becoming strengthened through programs such as the Community Development Education Program. There are many positive examples of communities working together to build resilience and develop community enterprise. Tatz speaks about the lift and dignity given back to communities through members being gainfully employed. However, the book also warns that such programs can be negative in that they have the potential to deny people any incentive and can potentially close off their already limited world, and do little to alleviate the underlying feelings of alienation and exclusion experienced by so many Aboriginal people.

When sifting through the research, it is clear that there are pockets of success being achieved by communities throughout Australia. Due to a number of reasons, these results are not widely publicised and the methods used are not being disseminated throughout other Indigenous communities. The MHCA is not suggesting that there is a one-size-fits-all approach to suicide within Aboriginal communities, in fact quite the opposite. However, it is important to ensure that the strategies leading to any successes be available as information for consideration by other communities facing similar problems.

At the moment the information collected about the problem of Indigenous suicide is done in a disjointed and ad hoc manner, with no accurate picture of the views about Indigenous suicide by Indigenous people, nor what they consider to be the solutions to this increasing problem. Tatz (1999) stresses that any attempt to identify the causes of and possible remedies for Aboriginal suicide needs an understanding of the differences that distinguish Aboriginal suicide from non-Aboriginal suicide. This can only be achieved by talking to Aboriginal community members.

What is clear is that the current strategy of addressing Indigenous suicide under the same framework as the general population by national suicide prevention strategies is ineffective. Farrelly (2004) points out that many Aboriginal suicide prevention initiatives are adapted from existing non-Aboriginal models which fail to take into account the cultures, customs and beliefs of Aboriginal people.

This is also recognised by Suicide Prevention Australia who recommends that strategies aimed at reducing the rate of suicide among Indigenous communities must be culturally-based to recognise and support the differences between Indigenous groups. They also stress the importance of genuine consultation with Aboriginal and Torres Strait Islander community groups, rather than indiscriminately adapting non-Indigenous models of suicide prevention. The role and potential of community-based, family-centred care giving and 'self-determination' as a protective factor must not be underestimated in this.

The MHCA recommends that a series of Indigenous Suicide Response Workshops to be conducted nationally throughout a large number of Indigenous communities to gain better information about the problems and the solutions at hand. These workshops would be modelled on the recently run MHCA Carer Engagement Workshops model, but with specific relevance to Indigenous communities in rural and remote locations.

 At the moment Indigenous people are constantly stating that they know what the problems are and what needs to be done, yet no-one is listening.   A series of workshops as described would allow for an accurate picture to be articulated by Indigenous community members, for Aboriginal community members.

Gay, lesbian, bisexual and transgender people

Available research examining the incidence of suicide and self-harm within gay, lesbian, bisexual and transgender (GBLT) communities demonstrates that these groups are at significantly higher risk than non-GLBT populations. Unfortunately the prevalence of suicide within these groups is unknown, but likely to be under-represented given the method of recording suicide as a cause of death (Beautrais, 1998; Remafedi, 1999). The evidence also suggests that most suicide attempts by GLBT people occur while still coming to terms with their sexuality and/or gender identity, and often prior to disclosing their identity to others (Dyson et al., 2003; Hillier & Walsh, 1999; Nicholas & Howard, 1998) or, for transgender individuals, before engaging in any gender-related treatment, such as counselling or therapy (Cole et al., 1997). Thus, sexual orientation and gender identity may not necessarily be known to family and friends at the time of death, thereby affecting figures (Bagley & Tremblay, 1997; Dyson et al., 2003; Hillier & Walsh, 1999).

Figures collected in the United States form a disturbing picture of the true nature and extent of suicide within GLBT groups. The United States Department of Health and Human Services estimates that up to 30% of all youth suicides may be performed by gay and lesbian youth aged between 15 and 24 years.

Recent studies in the US and Canada suggest that homosexuality issues are involved in up to one third of young men under 24 who suicide. A recent Australian study replicates these findings. In his study for the US Department of Health, Gibson (1989) stated that:

Suicide is the leading cause of death among gay male, lesbian bisexual and transsexual youth…Gay males were six times more likely to make an attempt than heterosexual males. Lesbians were more than twice as likely to try committing suicide than the heterosexual women in the study. A majority of the suicide attempts by homosexuals took place at age 20 or younger, with nearly one-third occurring before age 17.

Few studies have been carried out in Australia, but given the other social and cultural similarities between both the US and Australia, it would be reasonable to assume that this figure is similar for Australian GLBT youth.

Wesley Mission reports that GLB people, particularly youth, have a substantially increased risk of suicide and suicidal ideation. A number of studies show that suicide attempts are between 3.5 and 14 times higher than heterosexual youth (Bagley & Tremblay, 1997; Garofalo et al., 1998; Herrell et al., 1999; National Institute for Mental Health in England, 2007; Remafedi et al., 1998).

A recent Australian study found that gay males aged 18-24 years were 3.7 times more likely to attempt suicide. Most of these attempts occurred after the person had self-identified as gay, but before having a same-sex experience and before publicly identifying themselves as gay (Commonwealth Department of Health and Aged Care, 2000). Interestingly, studies examining the suicide rates of gay and lesbian youth appear to be lower than comparative rates of suicidal ideation (Nicholas & Howard, 1998). It is possible that this is related to the investigative process undertaken after death. If a person survives a suicide attempt, it is likely to be easier to establish whether a person is GLBT than if they are deceased.

Beyondblue (2009) recently completed a scoping study which suggested that same-sex attracted young people, particularly women, are highly susceptible to depression and suicide. They also revealed that bisexual youth are at higher risk of developing mental health problems than gay or lesbian youth. They highlight that there are a range of effective depression, mental health and mental illness treatments available, but that these need to be complemented with population-level discrimination and stigma reduction efforts.

Suicide Prevention Australia (SPA) recently reported a study by Nicholas and Howard (1998) which found that bisexual young people exhibited an even higher prevalence of self-harm than their exclusively gay and lesbian-identified peers at 29.4 and 34.9 per cent for bisexual males and females respectively. Unfortunately, no studies have been conducted on self-harm among transgender populations in Australia, however international studies report that rates of self-harming behaviour are high (SPA, 2009), particularly in the form of genital mutilation (Ontario Public Health Association, 2003).

However, it should be noted that a GLBT individual is not automatically at greater risk of suicide, with studies showing that the factors impacting on risk are more related to negative experiences such as heterosexism, homophobia and transphobia which contribute to social isolation, poorer mental health outcomes, substance use, and other sociocultural and economic problems and conditions (Dyson et al., 2003; Hillier & Walsh, 1999; Russell, 2003).

When discussing GLBT suicide, the first thing that becomes clear is that there is a serious paucity of information regarding this problem in Australia. Certainly, the available international evidence would suggest that GLBT youth are at greater risk than the non-GLBT youth population. What is also clear is that the stigma and discrimination experienced by GLBT youth is likely to seriously impact upon their mental health, increasing their chances of experiencing social isolation and family rejection.

The MHCA recommends that further research is conducted to understand the exact nature and extent of mental health issues impacting upon GLBT youth as well as the extent of suicide and attempted suicide within these groups, and to implement initiatives based on the findings of this research.

Rural and remote location living people

A study by Page and colleagues (2007) looked at the differences between urban and rural suicide rates from 1979-2003. It showed that there were major increases in young male (15-24 years) suicide rates between 1979 and 1998 and more so for young males living in remote areas from 1999-2003. In contrast, suicide rates in rural and metropolitan areas decreased from 1999-2003.

Although it is positive to see a reduction in suicide rates for any demographic group, it is important to view these changes against a longer timeline which will reveal that suicide rates tend to peak and trough over time. The point being that decreased suicide rates for any group is positive but this should only serve to inform future strategies rather than feeling satisfied that the job has been done. The study by Page and colleagues (2007) demonstrates that while the majority of 15-24 year old males may be experiencing reduced suicide rates, there are smaller sub-groups with greatly increased rates such as those living in remote areas or Aboriginal males.

It is well documented that access to services is a problem in rural and remote areas, which is undoubtedly negatively impacting upon groups living in these locations. A study by Taylor and colleagues (2005) has shown that socio-economic circumstances in rural populations contributes to higher male suicide rates compared to urban areas, but that this can be controlled somewhat by the availability and utilisation of mental health services.

It is not the intention of this section to overstate the problem of rural and remote area suicide rates. Rather, the MHCA would like to reinforce the importance of remaining focused on reducing suicide rates, even in times when they have reduced. The MHCA encourages government to maintain consistent and concerted efforts across all demographic groups, ensuring that complacency does not lead to increased mental health problems and suicide rates at a later date.

Culturally and linguistically diverse people

Despite the cultural and linguistic diversity that characterises the Australian population, there are significant gaps with regards to addressing suicide prevention for those from culturally and linguistically diverse (CALD) backgrounds. In addition to heightened risk factors present amongst some CALD groups, deficiencies in data collection and research, the lack of culturally appropriate mental health services, and ineffective referral mechanisms pose particular challenges in terms of reducing suicide and suicide attempts for those from CALD backgrounds.

Australia's population comprises a diversity of people from different backgrounds, with almost 44% born overseas or with one parent born overseas, and 16% estimated to speak a language other than English at home (ABS, 2006; DIAC, 2008). Within this culturally and linguistically diverse population, the factors contributing to suicidal ideation and the rates of suicide vary considerably amongst different ethnic minorities. However, whilst suicide rates tend to reflect the rates of suicide in the country of origin, existing evidence suggests that the average suicide rate for migrants is consistently *higher* in Australia than in the country of origin (McDonald & Steel, 1997; Steel & McDonald, 2000; Stewart 2005; Dusevic et al., 2002).

Furthermore, certain CALD sub-groups are at a heightened risk of suicide. Groups requiring specific focus include:

- *Elderly*. Amongst migrants from non-English speaking backgrounds, suicide rates for those aged over 65 are significantly higher than for the overall population; suicide rates for migrants aged above 75 have been found to be up to five times higher than for those aged 15-24. This applies to immigrants for countries with lower and higher suicide rates compared to the Australian-born population (Burville, 2000; McDonald & Steel, 1997; Steel & McDonald, 2000; Klimidis & Minas, 1999; De Leo, 2002). Given people from CALD backgrounds are the fastest growing sub-group of older people, the need to implement policy initiatives specifically targeting this group is imperative.

- *Asylum seekers and refugees.* Past experiences of torture and trauma, lack of familial and social support, racism and discrimination, and stresses associated with re-settlement are amongst the various factors associated with an elevated risk of suicide-related behaviours (Correa-Velez, 2005; Minas & Sawyer, 2002; Silove, 2004; Prasad-Ildes, 2006; Silove et al, 2006).

- *Rural / regional*. Studies have revealed that male immigrants in rural and regional Australia have twice the rate of suicide compared to male immigrants in metropolitan NSW (Morrell et al, 1999). Whilst current government policy favours resettlement in regional and rural locations, problems accessing appropriate and timely services are compounded for many CALD communities living in these areas.

- *Youth*. Whilst comprehensive data relating to CALD youth is sparse, services consistently report a high level of self-harming behaviour and suicide attempts by young people from refugee backgrounds. The lack of early prevention services to refugee youth, who constitute the largest proportion of humanitarian entrants, poses particular challenges in relation to suicide prevention. Experiences of racism, coupled with intergenerational and intercultural conflict, have been further identified as factors contributing to suicide attempts amongst CALD youth, including second-generation immigrants (Selvamanickam et al, 2001; Fry, 2000; Prasad-Ildes, 2006; Stewart, 2005)

- *Women.* Studies have indicated that females from a number of ethnic backgrounds have a significantly higher relative risk for suicide (Stewart, 2005; McDonald & Steel, 1997; Kliewer & Ward, 1998). This is particularly pronounced amongst older age cohorts.

A number of structural barriers contribute to the elevated risk factors experienced by certain CALD groups. People from CALD backgrounds are consistently underrepresented in preventative programs and in the utilisation of community mental health services, and overrepresented in involuntary admissions to inpatient facilities (Minas & Minas, 2009; Stolk et al, 2008; Sobolewska, 2005; Alizadeh-Khoei, 2008). In addition, it has been reported that those from CALD backgrounds are less likely to seek medical assistance as a result of a suicide attempt (Stewart, 2006; Fry, 2000). Mainstream or generic mental health services are often ill-equipped to cater for the needs of certain CALD individuals, lacking sufficient training or resources to work cross-culturally (Stewart, 2006). Uptake of interpreting services is also typically low within mainstream mental health agencies.

Whilst multicultural and ethnospecific agencies may be the first point of contact for CALD individuals at risk of suicide, staff within these services often lack sufficient training and resources to deal with mental health issues and to access mainstream support systems. The lack of coordination between multicultural community services and mental health services hampers efforts to address suicide in CALD communities. As a NSW-based study into suicidality amongst CALD communities highlighted, "there is a gap between mental health services and non-mental health services through which many people from CALD backgrounds are falling... [O]ften it is non-mental health workers who are coming into initial contact with and identifying suicidal people but these workers often don't feel qualified to manage the risks" (Stewart, 2006).

The heightened suicide risk experienced amongst some CALD groups, together with structural and systemic obstacles to culturally-appropriate service provision, are acknowledged in the Commonwealth Government's LiFe framework (2008). However, as with the other areas of need addressed in this submission, stated policy intent continues to lag behind policy implementation. Recent research indicates that disparities in the uptake of preventive and other mental health service representation are getting wider rather than narrower (Stolk et al, 2008; Minas & Minas, 2009). Whilst the outcomes of some localised suicide prevention initiatives targeting CALD groups have appeared promising, efforts have at best been piecemeal and ad hoc, lacking sufficient coordination with other interventions and revealing the absence of a long-term strategic approach.

The MHCA recommends a number of measures to address deficiencies in the current approach to suicide prevention amongst CALD communities. As with other at-risk groups, the lack of comprehensive data and research in relation to ethnicity and suicide poses a significant barrier to developing appropriately targeted, evidence-based policy. The limited number of demographic variables currently collected in suicide figures, coupled with inconsistencies across different jurisdictions, makes it difficult to accurately assess the differential rates of suicide amongst different CALD groups, along with the associated risk and protective factors.

The absence baseline data for CALD communities also poses issues in terms of accountability, making it difficult to monitor the effectiveness of policy initiatives. A recent review of suicide prevention research revealed that, of 209 published journal articles and 26 funded grants undertaken between 1999 and 2006, none specifically targeted CALD populations (Robinson et al, 2008). Only 2% of people conducting suicide prevention research were identified as targeting CALD peoples.

As this submission underscores, a nationally consistent and comprehensive approach to data collection and research must underpin any effective policy response to addressing suicide. This must include systematic data collection relating to ethnicity, with data collection methods consistent across state, territory and national jurisdictions. Research investigating community-based and clinical interventions and how they can be targeted to CALD groups must also be undertaken to identify effective strategies for preventing suicide.

In addition to improving research and data collection, the MHCA recommends a shift away from the short-term and ad hoc approach which has characterised efforts to address suicide amongst CALD groups. A comprehensive, coordinated and long-term approach is required that builds capacity at a systems, organisational and community level. Involvement of CALD communities in the development and implementation of specific components of this strategy is integral. This includes targeted programs addressing at-risk CALD groups, in addition to initiatives that enhance the capacity of mainstream services to cater to CALD communities. Improved referral systems need to be developed between multicultural community services, specialised CALD mental health services, and mainstream service providers. Community education initiatives tailored to CALD communities are also a vital element in preventing suicide amongst CALD communities.

Conclusion

In conjunction with the recommendations already made in the Joint Submission *Suicide is Preventable*, the MHCA believes that real improvement in the way Australia manage suicide can be achieved through strategic investment in three key areas:

- A new model of community mental health care and support

- A new commitment to accountability and research

- Specific and appropriate targeting of at-risk groups.

It is critical that investments made in these areas draw on the evidence of what works. Investments in suicide prevention strategies in Australia have not always done this in the past. Decisions about such investments should be made in a transparent manner and be informed by independent expertise.

Every suicide is a tragedy with an untold impact on loved ones, families, the community and the economy. Taking steps to prevent suicide is not only morally right, but economically sensible. Reducing the suicide rate is a fundamental responsibility for anyone concerned about the well being of Australians and the resilience of our communities.

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