4

A Strategic Approach to Youth Suicide

4.1 The current Chapter considers principles to embed in current and future youth suicide prevention programs. Three main principles were raised time and again during the Committee's series of roundtable discussions. These were outlined in the Committee's December 2010 discussion paper, and can broadly be termed:

- collaboration;
- mental health literacy; and
- 'gatekeeper' training.

4.2 The three principles are examined in the context of developing a strategic approach to youth suicide prevention which is coordinated, collaborative and inclusive.

Collaboration

4.3 Responsibility for addressing the numerous and complex factors linked to youth suicide is shared across all levels of government, across multiple portfolios and often requires linkages between the government and non-government sectors. As with any big policy challenge, there are real benefits to be had in the area of suicide prevention through collaboration. An issue as challenging as preventing youth suicide will have no single panacea or simple solution. Therefore working together across the community, the health sector and government will present the best approach to achieve real and significant reductions in the rate of youth suicide.

4.4 The idea of collaboration was raised by various groups throughout the Committee's roundtable forums and in written submissions. As stated by Ms Robinson from Orgyen Youth Health Research Centre (Orygen):

> Nobody wants to deal with this alone and that is why I think one of the things that we do need is a cross-sectoral, across government, really collaborative approach where we are working together and supporting each other so that nobody feels that they are left holding this huge responsibility by themselves.[1]

Collaboration with Young People

4.5 A discussion that was particularly impressive was the confidential discussion with young people following the Sydney roundtable forum held on 30 June 2010. In talking to these young people it became apparent that young people have definite ideas about how best to prevent youth suicide and the types of services that will work for them.

4.6 Consulting with young people and including them as partners when developing suicide prevention measures not only engenders a feeling of ownership, but also increases the chances that young people will engage with the process and that their needs are met. The importance of involving young people was well illustrated by *headspace* which engages with young people in the design of *headspace* centres. As explained:

> ... in all 30 *headspace* centres young people have been involved in the design of the centre and form part of the advisory structure for management and the consortium partners. Most importantly, the evidence suggests that most young people value our services. Under the umbrella of headspace, multiple organisations, including schools, come together to provide a one-stop shop for young people. This is not necessarily an easy process, but it is a process that is transacted within that community.[2]

Collaboration between Governments

4.7 Given the structure of the Australian health system, and the various federal, state and local governments that provide funding, there is a significant need for governments across Australia to collaborate with each

1 Ms J Robinson, Orgyen Youth Health Research Centre (Orgyen), Transcript of Evidence, 20 April 2010, p 31.

2 Mr C Tanti, *headspace*, Transcript of Evidence, 20 April 2010, p 23. See also: Commissioner for Children and Young People (WA), Submission No 19, p 3.

other to minimise duplication and maximise program benefits. As noted by *headspace*:

> Currently there is a flurry of activity in youth suicide programs and activities. Although there is some alignment with the Federal strategy it feels more like a scattergun approach to funding rather than a coherent national approach. Without coordination to pull these programs together and align the range of youth suicide strategies the impact of these programs will be lessened.[3]

4.8 Discussion with roundtable forum participants and information provided in written submissions indicate that there is scope for improvement in this area.[4] A significant concern raised in discussing collaboration between governments was that centralising of funding might inhibit the capacity for services to be locally responsive.[5] However, as one witness explained this concern can be addressed with appropriate collaboration between state and local governments:

> One of the key things from my perspective is that local government is quite good at managing local planning processes by saying, 'What are the public health issues that we want to address in our local area involving the different organisations and groups in the community and managing that whole process in an open and transparent way?' That is really useful. We are talking about coming in and developing a state-wide suicide prevention strategy based on local plans and we need to be able to link to local government.[6]

4.9 Collaboration also needs to occur within governments, across portfolios to achieve a response to the issue of youth suicide that is holistic. It is important that any youth suicide prevention strategy considers the underlying social determinants that increase risk, such as homelessness, limited engagement with education, unemployment, social isolation, drug and alcohol abuse.[7] As explained by the Australian Psychological Society (APS), poverty and social disadvantage have a detrimental effect on

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3 *headspace*, Submission No 14, p 7.

4 See for example: Ms M Perry, Centrecare, Transcript of Evidence, 31 January 2011, p 53.

5 Mr C Tanti, *headspace*, Transcript of Evidence, 20 April 2010, p 26.

6 Mr S Phillips, Ministerial Council for Suicide Prevention and Telethon Institute for Child Health Research, Transcript of Evidence, 15 February 2010, p 38.

7 See for example: *headspace,* Submission No 14, pp 7-8; Suicide Prevention Australia (SPA), Submission No 15, p 4; Australian Psychological Society (APS), Submission No 21, pp 9-10.

mental health and well-being, which in a vicious cycle can in turn perpetuate poverty and social isolation.[8]

4.10 A holistic approach to youth suicide prevention will require the establishment of clear linkages between specific youth suicide prevention policies and broader social policies which aim to address structural barriers to youth wellbeing, including socio-economic disadvantage.[9]

Collaboration between Service Providers

4.11 A significant point of fracture in the system aimed at preventing youth suicide is the lack of collaboration between service providers. There is a large range of services available to young people ranging from early intervention and prevention services to acute psychiatric care for people experiencing significant mental health difficulties or suicidal ideations. However, it seems that communication between these services is patchy at best, and non-existent at worst.[10]

4.12 A significant concern relates to the complexity and fragmentation of the service system. Evidence suggests that in some cases it is not the lack of services that is problematic, but rather difficulties in navigating a complex system to find appropriate assistance. The Committee was concerned to hear stories about people going through the yellow pages and ringing provider after provider trying to find the appropriate care and support. Again this was reiterated at the public roundtable discussion with one participant stating:

> ... There is currently no coordination of those services and it is incredibly complex, and the clients cannot find the services themselves. If we were clear about the structures in each community, we would certainly see more young people and more people getting services generally.[11]

4.13 Young people can be daunted and confused by the myriad of services available to them, to the point that they are actually unable to navigate the system to seek help. Better collaboration across government and between service providers would alleviate the significant problems of service complexity and fragmentation.

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8 APS, Submission No 21, pp 9-10.

9 SPA, Submission No 15, p 4

10 See for example: SPA, Submission No 11, pp 29-30; *headspace*, Submission No 14, pp 8-9; Mr C Tanti, *headspace*, Transcript of Evidence, 20 April 2010, p 27.

11 Mr C Tanti, *headspace*, Transcript of Evidence, 20 April 2010, p 27.

4.14 Another risk associated with a fragmented service system is the risk of those in need of assistance falling between the gaps, particularly at transition periods.[12] One of the critical periods for young people occurs at around 17 to 18 years of age, which often coincides with leaving the school system and associated supports and also moving from services for children and young people to accessing adult services. As noted by a participant at a roundtable forum discussion:

> There is a major problem within the system for 17 to 18 year-olds. The transition from child and adolescent to adult is where there is a major flaw in the system. Some people will not take you on if you are 17.6 or whatever because that deadline is looming for when you become an adult.[13]

4.15 Similarly, the submission from *headspace* notes:

> The current funding model of separate, disparate programs does little to ensure continuity, engagement and good outcomes for young people. The set up of services, largely based on funding models, treats children separately from young adults. In reality, young people access services in a similar manner. The cut off for service provision at the age of 18 in many health and community services is at odds with best practice for treatment, engagement and continuous care of this group.[14]

4.16 Moving from child to adult services is not the only transition point where young people risk falling between service gaps and not receiving the care and support they need. Discharge from tertiary health services into the community is another key transition point where young people at risk may fail to receive adequate continuity of care. The importance of a coordinated and seamless system to reducing the risk of youth suicide was summarised as follows:

> We know that suicide risk is greatest at the point of entry into a service and the point of discharge from the service. The fewer chinks there are in terms of a pathway through care, the less suicide risk there is also.[15]

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12 See for example: BoysTown, Submission No 10, p 5; SPA, Submission No 15, p 2; Youth Focus, Submission No 20, p 3.

13 Mr M Mitchell, Statewide Indigenous Mental Health Service, Transcript of Evidence, 31 January 2011, p 35.

14 *headspace*, Submission No 14, p 8. See also: BoysTown, Submission No 10, p 30.

15 Ms J Robinson, Orygen, Transcript of Evidence, 20 April 2010, p 28.

Committee Comment

4.17 The Committee strongly encourages the Australian Government to embed collaboration in its policy and program design and to show national leadership on this issue.

4.18 The Committee believes that the need to engage with young people in the design and implementation of services is self evident, and would like to see an emphasis on youth engagement in any future development of programs aimed at preventing youth suicide. One way in which the Australian Government could show leaderships in this regard is through engagement via the Australian Youth Forum (AYF). The Committee is aware that the AYF is currently seeking input from young people on mental health issues and their impact on young Australians.[16] Ideas and suggestions from young people will form a submission to inform the Minister for Youth. The Committee recommends that the views of young people on suicide and suicide prevention obtained through the AYF consultation are used to inform further development of the NSPS.

Recommendation 5

4.19 **The Committee recommends that the Australian Government, in consultation with state and territory governments and other key stakeholders, undertake appropriate consultation and engagement with young people to:**

- **further develop approaches to youth suicide prevention as part of the National Suicide Prevention Strategy;**
- **develop new youth suicide prevention initiatives and programs;**
- **evaluate existing youth suicide prevention measures; and**
- **share information.**

4.20 The Committee understands that collaboration across governments and between portfolios is essential to implementing a holistic and coordinated approach to the prevention of youth suicide. Therefore the Committee

16 Australian Government, Australian Youth Forum website, http://www.youth.gov.au/ayf/HaveASay/Pages/TopicDetails.aspx?TopicID=65, viewed on 7 June 2011.

strongly supports activities being progressed under the Council of Australian Governments' (COAGs') *Fourth National Mental Health Plan 2009-2014* to:

> 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.[17]

4.21 The Committee recommends that these activities also work to establish well defined cross portfolio linkages to existing government programs addressing issues of social and economic disadvantage, as well as drug and alcohol programs, which are known to increase the risk of youth suicide.

Recommendation 6

4.22 **The Committee recommends that the Australian Government establish well defined linkages with existing programs addressing issues of cultural, educational, employment, social and economic disadvantage, so that initiatives under the National Suicide Prevention Strategy are recognised as an integral part of a holistic approach to youth suicide prevention.**

4.23 As it stands the complexity and fragmentation of support services is an issue of concern, particular as this may result in young people at risk being unable to easily find what assistance is available or failing to receive continuity of care at critical transition points. Again the Committee is aware that continuity of care is a priority issue being addressed under COAGs' *Fourth National Mental Health Plan 2009-2014* with activities to:

> Improve communication and the flow of information between primary care and specialist providers, and between clinical and community support services, through the development of new systems and processes that promote continuity of care and the development of cooperative service models.[18]

17 *Fourth national mental health plan: an agenda for collaborative government action in mental health 2009-2014*, p 36.

18 *Fourth national mental health plan: an agenda for collaborative government action in mental health 2009-2014*, p 40.

4.24 As noted earlier, a significant time of increased risk for young people occurs as they transition from adolescence to adulthood. Coinciding as it often does with leaving school and the transition from child to adult health services, the risk of falling between gaps in services is of particular concern to the Committee. To mitigate this risk and promote continuity of care at this critical time, the Committee recommends the establishment of partnerships to facilitate referrals from school-based counselling services to community-based services that can be accessed after young people have left school.

Recommendation 7

4.25 **The Committee recommends that the Australian Government, in consultation with state and territory governments and non-government stakeholders, establish partnerships between departments of education and community-based service providers to ensure continuity of care for school leavers by facilitating referral of students to external counselling services where appropriate.**

4.26 However, the Committee recognises that some young people will only begin to experience difficulties after leaving the relatively supportive school environment with its strong social networks. In some circumstances this coincides with young people finding themselves socially and geographically isolated as they move into the workforce or higher education, leaving the family home and often living independently for the first time. Clearly, these young people will not be identified as requiring assistance until after they have left the school system. To address this, the Committee believes that a universal approach is required to ensure that school leavers are sufficiently well informed to recognise for themselves when they ought to seek help and are aware of the options available to them as young adults. This relates to broader issues of mental health literacy and social development education for young people which the Committee considers in more detail in the next section.

Mental Health Literacy

4.27 Ultimately any discussion about early intervention and suicide prevention involves some responsibility being borne by the person who is

experiencing difficulty in seeking help. Mental health literacy refers to a person's knowledge, beliefs and abilities that enable the recognition, management or prevention of mental health problems.[19] One of the reasons that mental health literacy is important in youth suicide prevention is that:

> ... for a lot of young people they have no frame of reference for what is going on with themselves. It is hard for them to understand whether they need a service or not.[20]

4.28 Throughout the inquiry, evidence suggests that some young people are reluctant to seek assistance, even when they are experiencing severe difficulties. The potential benefits of improving mental health literacy are multi-fold. Firstly, it empowers individuals to take responsibility for their own mental well-being, enabling them to seek help when they need it rather than falling through the cracks of a system that is unable to identify and target every single person who may require assistance. Moreover, increasing mental health literacy across the population will assist in de-stigmatising mental health difficulties.

4.29 The potentially important role of social development programs in promoting good mental health, well-being and resilience among young people and enabling them to better manage and cope with adversity was raised during roundtable discussions and in submissions. As observed by a roundtable participant:

> ... the area to emphasise is building individual resilience ... particularly with youth the idea that you can be a resilient person despite adversity is something that we really need to focus on.[21]

4.30 The *KidsMatter* suite of programs developed by *beyondblue* and run in some primary schools is an example of social development education that was frequently cited in evidence to the inquiry.[22] However, a representative from *beyondblue* indicated that the skills being taught require ongoing reinforcement, observing:

> Clearly there are a number of programs that schools have been using for some time, and they are generally resilience type, competency based programs. Primary schools are very germane to

19 APS, Submission No 21, p 9.

20 Mr C Tanti, *headspace*, Transcript of Evidence, 20 April 2010, p 15.

21 Dr D Watson, Royal Australian and New Zealand College of Psychiatrists (RANZCP), *Transcript of Evidence*, 20 April 2010, p 16.

22 See for example: SPA. Submission No 11, pp 15-16; *headspace*, Submission No 14, p 9; APS, Submission No 21, pp 6-7.

> this area because they have the curriculum space to be able to do this. In high schools it is very difficult to get curriculum space. Also, we are dealing with competencies that are developmental. Like with maths and literacy skills, you cannot go in there, do one session and say, 'There you go—there's your competency base and you're developed.' The skills are incremental and you do have to provide a progression through the skills.[23]

4.31 In addition to school based social development programs, it would seem that the internet and social media present important opportunities to engage with young people and foster discussions about mental health and wellbeing. As outlined below, the benefit of these technologies is that:

> There is an opportunity to provide access points online through organisations like Inspire and our REACHOUT.com initiative, plus also going into the social networking spaces where young people are, such as Facebook and Twitter, which young people are using on a daily basis to actually create conversations around mental health, wellbeing and indeed suicide.[24]

4.32 Evidence also suggests the community as a whole is generally lacking in mental health literacy. A number of contributors to the inquiry suggested increasing mental health literacy through the implementation of sustained national awareness-raising campaigns targeting youth suicide.[25] Although there was broad consensus that awareness campaigns should focus on preventative care, promote help-seeking, resilience and wellbeing among individuals and communities, at least one submission suggested that further research was needed to establish their value.[26]

Committee Comment

4.33 On the basis of evidence to the inquiry it seems that increasing mental health literacy is likely to make a significant contribution to reducing youth suicide rates. In particular, the Committee believes that school-based social development programs which promote good mental health, well-being and resilience among young people are crucial. The Committee understands that delivery of these programs through schools will have a number of benefits. Firstly, delivery of these programs through schools

23 Dr B Graetz, *beyondblue*, Transcript of Evidence, 20 April 2010, p 19.

24 Ms M Blanchard, Inspire Foundation, Transcript of Evidence, 20 April 2010, p 22.

25 See for example: Lifeline Australia, Submission No 2, p 7; Inspire Foundation, Submission No 4, p 9; SPA, Submission No 15, p 5.

26 RANZCP, Submission No 3, p 13.

will ensure that they reach the vast majority of children and young people. Secondly, universal involvement of all students in this type of education will eliminate the perception of stigmatisation, which could be problematic if delivered to 'at risk' students only.

4.34 The Committee is encouraged by announcements made in the 2011-12 Budget which indicate that the *KidsMatter* suite of programs will receive additional funding. However, as evidence suggests the need for social development education to be reinforced throughout childhood and adolescence, the Committee is concerned that announcements did not include increased support for the *MindMatters* program which provides social development education at secondary school level. The Committee sees the continued development of a national curriculum for Australia as an opportunity to ensure that social development education is included as a core component for kindergarten to year 12. The Committee understands that the national curriculum is being progressively developed by the Australian Curriculum, Assessment and Reporting Authority (ACRA). The Committee recommends that ACRA include social development education as a core component of the national curriculum for primary and secondary schools.

Recommendation 8

4.35 **The Committee recommends that the Australian Curriculum, Assessment and Reporting Authority include social development education and mental health as a core component of the national curriculum for primary and secondary schools.**

4.36 In the previous section, the Committee noted the increased risks for young people as they transition from adolescence to adulthood, coinciding as it often does with leaving school. The Committee has identified continuity of care as a critical issue and recommended facilitating referrals for young people already experiencing difficulties. However, for those young people whose difficulties do not manifest until after leaving school, the Committee believes that a universal approach is essential to ensure that they are sufficiently informed to recognise for themselves when they ought to seek help, and aware of the options available to them as young adults. Therefore, The Committee recommends that social development and mental health education for older secondary school students include specific components to assist them be better prepared for moving from

school into the workforce or higher education, and aware of the full range of services available to assist them as they transition from child to adult services.

Recommendation 9

4.37 **The Committee recommends that social development and mental health education for older secondary school students include specific components to assist them to be better prepared for moving from school into the workforce or higher education, and aware of the full range of services available to assist them as they transition from child to adult services.**

4.38 The Committee agrees that there is a need to improve mental health literacy at community level. This issue was considered in detail by the Senate Community Affairs Committee which made four recommendations in support of a sustained awareness raising campaign to encourage help-seeking and to address some common misconceptions relating to suicide. In its response to these recommendations the Australian Government provided only qualified support stating that:

> In the absence of substantial international and national evidence, and in light of a lack of consensus in the suicide prevention sector and among experts in the field, the Government is not convinced that a national, multi-media social marketing campaign is the best way to provide this targeted information.[27]

4.39 Therefore, while supportive in principle of social marketing campaigns to increase mental health literacy, the Committee understands the need for a robust evidence-base to justify the allocation of significant resources.

'Gatekeeper' Training

4.40 One of the difficulties with early intervention is identifying individual that need support and ensuring that they get it. While noting that some have

27 Commonwealth Response to *The Hidden Toll: Suicide in Australia:* Report of the Senate Community Affairs Reference Committee, p 40.

expressed reservation with the use of this term[28], in this context it is simply used to describe a diverse range of individuals who have regular contact with young people. These people include family, friends, teachers, youth workers, sports coaches, health professionals, law enforcement and emergency services personnel. As noted in the submission from the Australian Psychological Society:

> Each of these groups of people play two critical roles: to act as 'detectors' and monitor for early warning signs of young people at risk; and to act as 'facilitators' – alerting and making appropriate referrals to specialist service providers as required.[29]

4.41 Evidence suggests that building mental health literacy and providing ongoing training for people who have regular contact with young people so that they are better equipped to recognise early warning signs and make appropriate referral is likely to have benefits.[30] Representing Lifeline Australia, Mr Alan Woodward reported:

> We have found through our training of community personnel and what are known as 'gatekeepers'—our health workers, youth workers and social workers and the like; people who are likely to come into contact with a suicidal person—that being able to explore that issue and provide an immediate and appropriate response is a very important step. We believe that that is also an area of suicide prevention which is known to be effective internationally and could be invested in further in Australia.[31]

4.42 At a roundtable discussion, a representative of Orygen emphasised the important role of teachers and school counsellors in early detection and either referral or treatment, noting:

> We know that when [high risk young] people do seek help one of the first ports of call for them is teachers or school counsellors. We also know that school counsellors generally feel quite overburdened and overstretched and that they feel overwhelmed and underskilled in terms of responding. Some specific training around managing young people who are at risk and working with

28 APS, Submission No 21, p 7; Dr D Watson, RANZCP, Transcript of Evidence, 20 April 2010, p 8.

29 APS, Submission No 21, p 7.

30 See for example: RANZCP, Submission No 3, p 12-13; Dr B Graetz, *beyondblue*, Transcript of Evidence, 20 April 2010, p 18.

31 Mr A Woodward, Lifeline Australia, Transcript of Evidence, 30 June 2010, p 23.

> people who engage in self-harm for those sorts of populations would be incredibly beneficial.[32]

4.43 In discussions with young people during the inquiry, it became evident that there had been a diversity of experiences in terms of the support that they received when dealing with difficulties. For example, a young person whose brother had suicided told of not being supported by the school principal. Another young person recounted an experience when she found herself the victim of significant bullying and harassment. She approached a teacher for assistance, only to be told that it was simply a case of 'tall poppy syndrome'. In contrast, other young people reported receiving significant support from teachers, with one young person telling of being approached by a concerned teacher and referred to KidsHelpline.

4.44 Although not suggesting that the information above is indicative of a widespread or systemic problem within schools, the diversity of experiences does at least illustrate that some teachers and school counsellors feel inadequately resourced or ill-equipped to deal with these situations.

4.45 According to Ms Joanna Robinson of Orygen, there is also good quality evidence to suggest that gatekeeper training targeted at general practitioners has a significant effect in reducing the risk of suicide:

> One of the most effective suicide prevention strategies that has been shown internationally is the improved training of general practitioners in assessing and managing young people, or people in general, at risk of suicide. That can lead to a reduced suicide rate. Some of the strongest evidence in suicide prevention is around GP training. So we can better train people and better equip them, and give them the confidence to hold young people at risk. Young people might just need monitoring or some supportive response.[33]

4.46 In addition to training for professionals, others such as family and friends could also benefit from education to assist them to identify early warning signs and determine when professional assistance is required. Mental health education, which could incorporate suicide prevention education, can be incorporated into professional development training for those groups who interact with young people in a professional or formal capacity. Education for non-professional gatekeepers such as parents and

32 Ms J Robinson, Orygen, Transcript of Evidence, 20 April 2010, p 19.

33 Ms J Robinson, Orygen, Transcript of Evidence, 20 April 2010, p 29.

peers may be more challenging and require proactive dissemination strategies, rather than relying on individuals themselves to initiate information seeking.[34] To be effective, it is recommended that training and education is tailored to suit specific professional and non-professional groups.

Committee Comment

4.47 The Committee understands that early detection and access to appropriate assistance is critical to the prevention of youth suicide. The Committee has already commented on how increasing mental health literacy may assist young individuals and others in the community to better recognise risk. The Committee sees gatekeeper training as an extension of mental health literacy, particularly as it applies to professionals who deal with young people during the course of their day-to-day work.

4.48 Again the Committee is aware that workforce development and training was considered in detail by the Senate Community Affairs Committee in its report on suicide in Australia. The Senate report makes four recommendations relating to suicide awareness, risk assessment and prevention training.[35] Two of the four recommendations relate to training for professional 'frontline' staff, including those in health care, law enforcement, correctional services, child and family services and education. The two other recommendations call for greater access to this type of training for community-based organisations and for gatekeeper training to be directed to people working and living in rural and remote areas. The Committee endorses these recommendations. It is pleased to note that the Australian Government has already commenced work in some areas, and where appropriate is in discussions with state and territory jurisdictions.

4.49 Considering youth suicide prevention specifically, it is clear that family, friends and teachers have a significant role when it comes to managing the wellbeing of young people. Importantly, the Committee does not expect these groups to assume the role of counsellor. Rather the Committee considers that it would be useful for parents, peers and teachers to be trained to recognise the signs of mental distress and be equipped to start a conversation providing at risk young people with advice on the resources that are available or putting them in contact with a specialist service.

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34 APS, Submission No 21, pp 8-9.

35 Commonwealth Response to *The Hidden Toll: Suicide in Australia:* Report of the Senate Community Affairs Reference Committee. (see Recommendations 8, 15, 16 &31).

4.50 While acknowledging that teachers are already carrying significant responsibility when it comes to the health and well-being of young people, the Committee believes that they are ideally placed as professionals that have regular contact with young people to play a significant role in early identification of young people who may be experiencing difficulties and needing assistance. Therefore the Committee recommends that teachers receive mandatory training on mental health awareness, including specific training to develop their capacity to recognise and assess suicidal risk.

Recommendation 10

4.51 **The Committee recommends that teachers receive mandatory training on mental health awareness, including specific training to develop their capacity to recognise and assess suicidal risk.**

4.52 The Committee understands that a number of training resources for professionals and non-professionals alike already exist. While generally supportive of the concept of gatekeeper training, in concluding its consideration the Committee notes that there has been no systematic evaluation of effectiveness of these programs in reducing rates of youth suicide. Clearly, the Committee would support a systematic review to establish an evidence base and inform best practice.

Mr Steve Georganas MP
Chair