The Parliament of the Commonwealth of Australia

Before it's too late:

Report on early intervention programs aimed at preventing youth suicide

House of Representatives
Standing Committee on Health and Ageing

July 2011
Canberra

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Foreword

Every year in Australia suicide claims the lives of around 2000 Australians placing it ahead of road traffic accidents and skin cancer as a cause of death. For young people aged 15 to 24, it is the number one cause of death. Despite this, in recent years the issues of mental health and suicide prevention have received comparatively less mainstream policy attention and seemingly less program funding than well resourced and public road safety and sun protection campaigns. The tide is starting to turn. New, strong and ever growing community engagement with these issues now place mental health and suicide prevention firmly on the national policy agenda for political parties of all persuasions who recognise both the complex nature of the issue but also the impact that a single suicide can have on families, communities, schools and workplaces. There has also been a noticeable shift toward more open discussion and debate surrounding the issue of suicide including the role the media play in reporting on the issue; an important conversation to have particularly in the social media era.

Despite the alarming statistics the Inquiry has found some encouraging results to show that the situation can be improved. Evidence presented has suggested that as a result of measures taken by successive Governments, the rate of youth suicide has been in decline since 1997. The Committee's investigation, which included roundtable discussions with young people and community organisations, focussed on the potential for early intervention programs to further reduce rates of suicide in this age group. These discussions highlighted to the Committee, the important role that young people play in the development of early intervention strategies aimed at assisting their peers. The Committee was impressed by the number of young people who contributed to the work of organisations through volunteering and by holding positions of responsibility.

In terms of formulating its recommendations, the Committee would particularly like to thank the young people who provided confidential, yet candid accounts of their experiences to the Committee in Sydney in 2010. Their contribution was invaluable and the courage demonstrated in speaking to the Committee about a very sensitive issue was appreciated by all Members of the Committee. Their

stories were a testament to the resilience and determination of many young people in Australia who have battled mental health issues or have contemplated taking their own lives.

The Committee has used the evidence presented to it make a number of recommendations which it hopes will lead to better policy and program outcomes. Key recommendations include approaches to reducing the rate of youth suicide, research and evaluation to inform best-practice strategies, collaboration, increasing mental health literacy and 'gatekeeper' training.

I would like to take this opportunity to thank my Committee colleagues for their contributions to the report. I would also like to thank the Committee Secretariat for all their assistance and help. I would also like to thank the witnesses who spoke to the Committee in Canberra, Sydney, Melbourne and Perth, along with those who made written submissions to the inquiry.

Mr Steve Georganas MP
Chair

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43rd Parliament

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Deputy Chair	Mr Steve Irons MP	
Members	Mr Mark Coulton MP	Ms Deb O'Neill MP
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42nd Parliament

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	Ms Sharon Bryant *(to 23/2/11)*
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Research Officers	Ms Belynda Zolotto
	Mr Thomas Gregory
Administrative Officers	Mr Shaun Rowe
	Ms Claire Young

42nd Parliament

Secretary	Ms Sharon Bryant
Inquiry Secretary	Ms Penny Wijnberg
Administrative Officers	Mrs Jazmine Rakic
	Mr Shaun Rowe

Terms of Reference

That the House of Representatives Standing Committee on Health and Ageing, after reviewing the 2008-2009 annual report of the Department of Health and Ageing and pursuant to Standing Order 215(c), take evidence on the topic of youth suicide.

List of Recommendations

Recommendation 1

The Committee recommends that the National Committee for the Standardised Reporting of Suicide consider options for, and the feasibility of, extending the scope of social and demographic suicide data routinely collected and reported on, to include information on:

- ethnicity;
- culture;
- geography;
- educational attainment;
- employment status; and
- socio-economic status. *(para 2.23)*

Recommendation 2

The Committee recommends that the National Committee for the Standardised Reporting of Suicide consider options for providing increased access to disaggregated suicide data. *(para 2.24)*

Recommendation 3

The Committee recommends that the Australian Suicide Prevention Advisory Council liaise with the National Health and Medical Research Council, the Australian Research Council, government departments (including state and territory government departments) and other agencies with a role in this domain, to develop a priority research agenda for youth suicide, with a view to jointly supporting a coordinated and targeted program of research. *(para 3.42)*

Recommendation 4

The Committee recommends the Department of Health and Ageing, in conjunction with state and territory governments, facilitate the sharing of evaluations of existing programs and youth-suicide research across the entire suicide-prevention sector, through the establishment and maintenance of an online program-evaluation clearinghouse. *(para 3.50)*

Recommendation 5

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;
- development new youth suicide prevention initiatives and programs;
- to evaluate existing youth suicide prevention measures; and
- share information. *(para 4.19)*

Recommendation 6

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. *(para 4.22)*

Recommendation 7

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. *(para 4.25)*

Recommendation 8

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. *(para 4.35)*

Recommendation 9

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. *(para 4.37)*

Recommendation 10

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. *(para 4.51)*

1

Introduction

1.1 Suicide is one of the most common causes of death for young people in Australia, accounting in 2005 for approximately 20 percent of all deaths of those aged between 15 and 24 years of age.[1] This figure is considerably lower than the peak youth suicide rate in 1997, where suicide accounted for 21 percent of deaths in the ages 15 to 19 and 34 percent of deaths in the ages 20 to 24.[2] Suicide is the second most common cause of death in young people, after transport accidents which, in some years, account for up to 44% of youth deaths.[3]

1.2 The rate of suicide for young males is even higher than the general youth rate, and much higher than the rate of suicide in older males – accounting for almost one quarter of all deaths in males between the ages of 15 and 24. Similarly, suicide is much more common in young females than in older females.[4]

1.3 Although the rate of youth suicide remains distressingly high, it appears that measures to reduce youth suicide rates may have had significant impact, as evidenced by the decline in suicide rates since 1997. Therefore, in November 2009 the House of Representatives Standing Committee on Health and Ageing of the 42nd Parliament (the former Committee) resolved to conduct an inquiry to examine the potential for effective intervention programs to further reduce rates of youth suicide.

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1 Australian Bureau of Statistics (ABS), *Suicides, Australia 2005* (2007), cat no 3309.0, p 13.

2 ABS, *Suicides, Australia 2005* (2007), cat no 3309.0, p 13.

3 Australian Institute of Health and Welfare (AIHW), *Injury among young Australians*, Bulletin 60 (2008), cat no AUS 102, pp 1-2.

4 ABS, *Causes of Death, Australia 2009* (2011), cat no 3303.0, p 26.

Conduct of the Inquiry

42nd Parliament

1.4 Although the former Committee was aware that the Senate Community Affairs Reference Committee had already initiated a comprehensive inquiry into suicide in Australia, it felt that a House of Representatives inquiry, if appropriately focussed, could complement that work. Therefore, in February 2010, while in Perth, the former Committee sought an initial briefing to assist in refining the scope of its inquiry. Organisations represented at the briefing included Youth Focus, Fremantle Headspace, Telethon Institute for Child Health and OZHELP (WA). During the briefing participants described the work that they undertake to prevent youth suicide, and identified priority issues for further consideration. As a result of the briefing the former Committee refined its terms of reference to focus the inquiry on 'the need for and success of early intervention programs aimed at preventing youth suicide'.

1.5 The former Committee also decided that a series of roundtable forums would be the best way to progress the inquiry, as this would afford opportunities for interested individuals to discuss the issues in an interactive way. To this end the former Committee convened two public roundtable forums, in Melbourne on 20 April 2010 and in Sydney on 30 June 2010, with a diverse range of professionals working in the field of youth suicide prevention. While the former Committee was in Melbourne, Members also took the opportunity to visit a Headspace site and to meet with staff and youth representatives. The former Committee also expressed a desire to meet with and hear from young people directly. A confidential discussion session with a number of young people was convened as part of the Sydney roundtable. Although there was no formal request for written submissions, 12 submissions and 21 exhibits were received. The inquiry lapsed on 19 July 2010, the date on which the House of Representatives was dissolved ahead of the August 2010 federal election.

43rd Parliament

1.6 The 43rd Parliament was opened on 28 September 2010 and the current House of Representatives Standing Committee on Health and Ageing was established under House of Representatives standing order 215 on the following day. On Tuesday 16 November 2010, the current Standing Committee on Health and Ageing (the Committee) resolved to re-adopt

the *Inquiry into the need for and success of early intervention programs aimed at preventing youth suicide* from the previous Parliament. In resolving to do so however, the Committee recognised that the former Committee had been unable to report on the inquiry in the 42nd Parliament.

1.7 Therefore, the Committee decided to publish a discussion paper drawing together the evidence that had already been presented, highlighting emerging themes and inviting comment from those who had participated in the inquiry to date.[5] The themes presented in the discussion paper were broadly categorised as:

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

1.8 The discussion paper also outlined a number of policy proposals that had emerged during 2010 to address youth mental health issues and reduce rates of youth suicide. These policy proposals were:

- the need for more frontline services including psychological and psychiatric services;
- additional support for communities affected by suicide;
- targeting those who are at greatest risk of suicide;
- promoting mental health and well-being among young people;
- additional youth 'headspace' sites; and
- additional Early Psychosis Prevention and Intervention Centres.

1.9 The discussion paper was published on the Committee's webpage in December 2010. It was also distributed to those organisations that had engaged with the inquiry in the 42nd Parliament, with an invitation to submit further comment. The Committee received an additional 15 submissions (including supplementary submissions) and 28 exhibits. A list of submissions is at Appendix A. Exhibits are listed at Appendix B.

1.10 In early 2011, the Committee held two further roundtable forums in Perth on 31 January 2011 and in Canberra on 11 February 2011. The schedule of public briefings and roundtables is at Appendix C.

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5 Parliament of Australia, House of Representatives Standing Committee on Health and Ageing, *Discussion Paper for the Inquiry into Early Intervention Aimed at Preventing Youth Suicide* (December 2010).

Senate Committee Inquiry and Report

1.11 In addition to publication of the Committee's discussion paper, the Senate Community Affairs References Committee tabled its report, *The Hidden Toll: Suicide in Australia,* in June 2010. The report makes 42 recommendations addressing ways to improve responses to suicide in Australia.[6] In summary the recommendations call for:

- an assessment of the social and economic costs of suicide;
- continued and expanded support for the activities of the National Committee for Standardisation of Reporting on Suicides, the standardisation of suicide reporting and improved data collection and reporting;
- enhanced suicide awareness and prevention training for front-line workers (e.g. people working in primary care, law enforcement and emergency workers);
- affordable access to crisis and counselling services, including telephone and on-line services;
- mechanisms to improve the 'connectedness of services' and continuity of care;
- long-term awareness campaigns using a range of media, including campaigns targeted at high risk groups;
- more programs and increased program funding for at risk groups; and
- additional Early Psychosis Prevention and Intervention Centres.

1.12 In November 2010, the Government responded to the Senate report's recommendations, noting:

> Of the 42 recommendations the Government has already actioned six, has set in place initiatives to meet a further twenty, and will progress or consider the remaining recommendations in consultation with relevant stakeholders.[7]

1.13 The Committee notes the recommendations made by the Senate Committee and the Government responses. The Committee views its own report on youth suicide as a complement to that comprehensive report and its recommendations.

6 Parliament of Australia, Report of the Senate Community Affairs References Committee, *The Hidden Toll: Suicide in Australia* (June 2010).

7 Commonwealth Response to *The Hidden Toll: Suicide in Australia*, Report of the Senate Community Affairs References Committee (November 2010).

Structure of the Report

1.14 Chapter 2 presents an overview of suicide statistics, with a focus on suicide statistics for the 14-25 years age-group. It reviews what is known about risk and protective factors youth suicide and identifies groups of young people who are at increased risk.

1.15 Chapter 3 examines the various theoretical approaches used to reduce the suicide rates among young people, with a focus on prevention and early intervention. The Chapter provides a review of Australian Government youth suicide prevention strategies and the role of research and evaluation in developing a robust evidence-base to inform future best-practice strategies for youth suicide prevention.

1.16 Chapter 4 expands on guiding principles that were outlined in the Committee's discussion paper, examining them in the context of developing a coordinated, collaborative and inclusive approach to preventing youth suicide.

2

Understanding Youth Suicide

2.1 To establish the basis for the Committee's focus on the issue of youth suicide and early intervention, this Chapter presents an overview of the statistics on suicide in Australia, and youth suicide in particular. The difficulties associated with collecting accurate and comprehensive suicide data are considered. The Chapter also presents an overview of the factors which affect the likelihood of youth suicide, and identifies groups that are at increased risk of suicide.

Statistics on Suicide in Australia

2.2 Statistics on suicide in Australia are available from a number of sources. National data on suicide is published in some years by the Australian Bureau of Statistics (ABS). The most recent, published in 2007, contains summary statistics on deaths registered in 2005 where the cause of death was determined to be suicide.[1] Even more recent, though less comprehensive, statistics on suicides in Australia are published annually in the ABS 'causes of death' reports. The 2011 *Causes of Death Report* provides information on suicides based on mortality data from 2009.[2] Coroners, through the National Coroners Information System (NCIS), are another significant source of suicide data. In addition, the Australian Institute of Health and Welfare (AIHW) has also produced a number of publications based on information extracted from the AIHW Mortality Database.[3] These data are supplemented by data collection and research

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1 Australian Bureau of Statistics (ABS), *Suicides, Australia 2005* (2007), cat no 3309.0.

2 ABS, *Causes of Death, Australia 2009* (2011), cat no 3303.0.

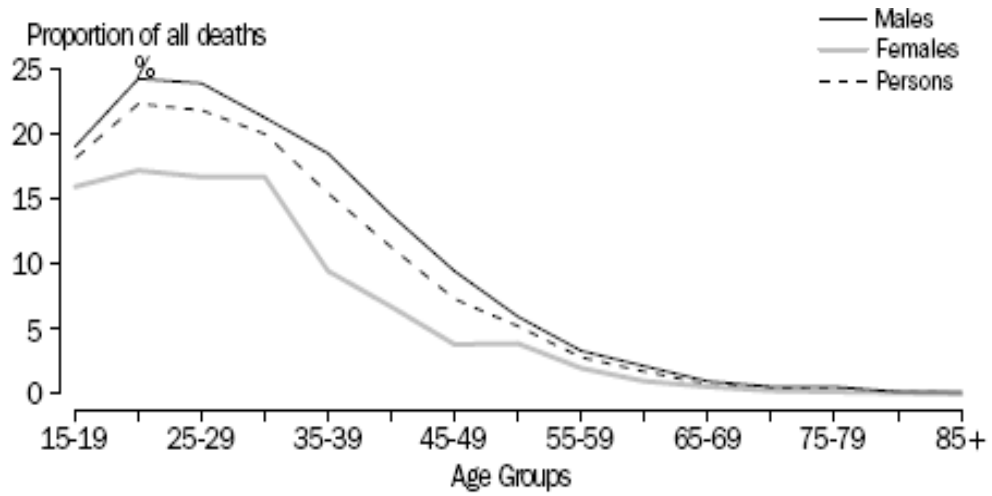
3 Australian Institute of Health Welfare (AIHW) website, http://www.aihw.gov.au/aihw-national-mortality-database/, viewed on 20 May 2011.

conducted by academic institutions and by community based organisations.

2.3 Although not intended to be a comprehensive review of suicide in Australia, the following section provides key information on suicide rates, trends and 'at risk' groups. According to the ABS, in the year 2009 suicide was the registered cause of 2,132 deaths, making it the 14th most common cause of death in the population generally.[4] Across all age-groups suicide is much more common in males than females, with over three-quarters (76.6%) of suicides in 2009 being males. Suicide was the 10th most common cause of death in males that year.[5]

2.4 While suicide accounts for only a relatively small proportion (1.5%) of all deaths in Australia, as shown in Figure 2.1, suicide is a disproportionate cause of death in some age groups. In 2009, 24% of all male deaths aged 15 to 24 years were due to suicide. Similarly for females, suicide deaths comprise a much higher proportion of total deaths in younger age groups.[6]

Figure 2.1: Suicides by Selected Age Groups: 2009



Source: ABS, Causes of Death, Australia 2009 (2011), cat no 3303.0 2009

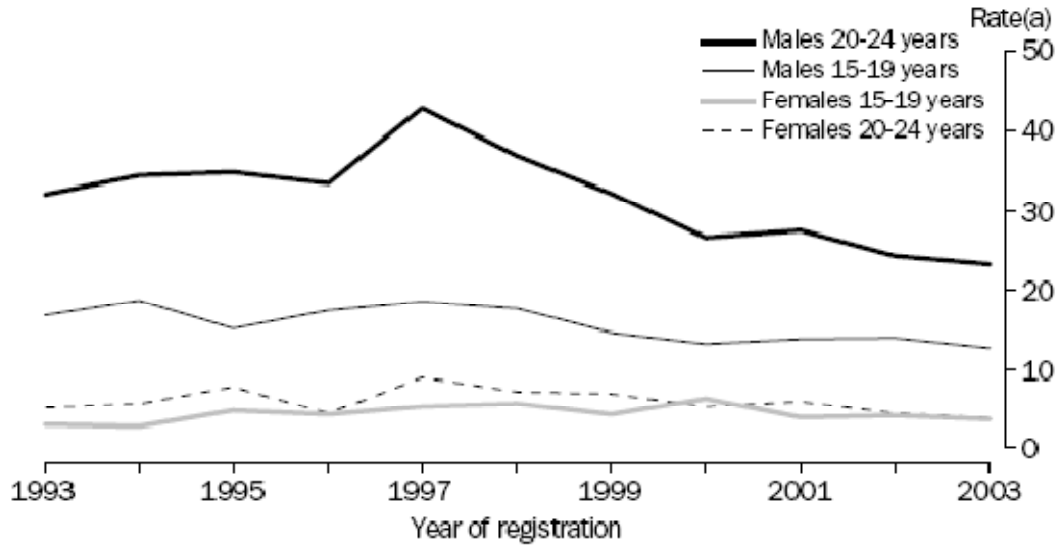
2.5 Further examination of the data reveals a more complex picture of youth suicide.[7] Data from 2008 indicates that men aged 20 to 24 years were

4 ABS, *Causes of Death, Australia 2009* (2011), cat no 3303.0, p 25.
5 ABS, *Causes of Death, Australia 2009* (2011), cat no 3303.0, p 25.
6 ABS, *Causes of Death, Australia 2009* (2011), cat no 3303.0, p 26.
7 ABS, *Suicides, Australia 2005* (2007), cat no 3309.0, p 7.

particularly vulnerable to suicide, with a rate of around 19 suicides per 100,000. This is a higher rate than for young men aged 15 to 19 years with around 9 suicides per 100,000 men in 2008. Data from 2008 for young women, records rates of 3 suicides per 100,000 women aged 15 to 19 years and 5 suicides per 100,000 women aged 20 to 24 years.

2.6 Data from the ABS also shows that youth suicide rates fluctuate over time (Figure 2.2). A general decline in youth suicide rates has been recorded since the late 1990s. In 1997, suicide rates for 15 to 19 year old males peaked at 18.4 per 100,000, decreasing consistently over the next decade, and in 2009 the rate was 9.3 per 100,000 in this age group.[8] A more dramatic decrease in suicide rates over the same period was observed in young men aged 15 to 24 years, decreasing from 42.8 per 100,000 in 1997 to 19 per 100,000 in 2009. In contrast, the suicide rate for females aged 15 to 19 years has remained relatively stable over the same period at around 3-5 per 100,000. In 2009, the suicide rate in females aged 15 to 19 years was 3.4 per 100,000.[9]

Figure 2.2: Age-Specific Suicide Rates: 1993 to 2003



Source: ABS, Suicides: Recent Trends, Australia 1993-2003 (2004), cat no 3309.0.55.001

8 ABS, *Suicides, Australia 2005* (2007), cat no 3309.0, p 4; ABS, *Causes of Death, Australian 2009* (2010), cat no 3303.0, p 27.

9 ABS, *Suicides, Australia 2005* (2007), cat no 3309.0, p 4; ABS, *Causes of Death, Australia 2009* (2010), cat no 3303.0, p 27.

2.7 Suicide in children under the age of 15 years is rare. Over the period 1995 to 2005, the reported suicide rate in children under 15 years averaged 0.25 per 100,000.[10]

2.8 A significant body of research also indicates that youth suicide differs greatly across Australia and between social groups. Data indicates that Indigenous young people aged 12 to 24 years had suicide rates up to four times higher than non-Indigenous Australians in the same age group. Between 2001-03 suicide rates for Indigenous young people were 37 per 100,000 compared to 8 per 100,000 for non-Indigenous young people.[11]

2.9 Data also suggests that suicide rates for young people aged 15 to 24 years were elevated for those living in rural and remote locations, with a suicide rate three times that of their counterparts living in major cities.[12] This appears to be particularly the case for young men.[13] The AIHW also reports higher suicide rates for young people living in the most socioeconomically disadvantaged areas of Australia, with rates of 13 per 100,000 compared to 9 per 100,000 in 2003-05.[14]

2.10 Although there is a paucity of data on suicide in culturally and linguistically diverse (CALD) populations, available research suggests that there may be significant variation in patterns of suicide across cultures. For example, while noting that the research referred to is not particularly recent, the Diversity Health Institute notes that amongst people with a non-English speaking background, suicide attempts are higher amongst females than males. This represents a marked difference from the general population.[15]

2.11 Although data is not routinely collected, research has also identified other groups of young people who may be at increased risk of suicide. These include (in no particular order):

- victims of bullying, including cyber-bullying, harassment and discrimination[16];

10 ABS, *Suicides, Australia 2005* (2007), cat no 3309.0, p 17.

11 ABS & AIHW, *Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples* (2008), cat no 4704.0, p 169. See also: AIHW, *Injury among young Australians*, Bulletin 60 (2008), cat no AUS 102, p 29.

12 AIHW, *Injury among young Australians*, Bulletin 60 (2008), cat no AUS 102, p 30.

13 AIHW, *Rural, regional and remote health: a study on mortality*, 2nd Edition (2007), cat no PHE 95, pp 201-202.

14 AIHW, *Injury among young Australians*, Bulletin 60 (2008), cat no AUS 102, p 30.

15 Diversity Health Institute, Submission No 12, p 1.

16 BoysTown, Submission No 10, p 15; Diversity Health Institute, Submission No 10, p 7; Women's Health Victoria, Submission No 18, p 2-3.

- gay, lesbian, bisexual, transgender and intersex individuals[17];
- those who are socially isolated or homeless[18];
- individuals with mental illnesses (especially depression and anxiety)[19];
- those in the juvenile justice system;
- those using drugs and alcohol[20];
- individuals who engage in self harm[21] or who have previously attempted suicide; and
- individuals who have experienced trauma (particularly where unresolved), grief, loss, and family breakdown.[22]

Collecting and Reporting Suicide Statistics

2.12 Issues relating to the quality of suicide data were a common theme raised in evidence.[23] As indicated above, there is a range of data currently collected around Australia relating to suicide, with the main source of data being the ABS. However, it is also clear that there are difficulties associated with collecting data on suicide. As a consequence suicide data is acknowledged to be incomplete and of varying quality.

2.13 ABS and AIHW reports on suicide and mortality include frequent references to technical notes which emphasise that suicide statistics must be interpreted cautiously. A significant concern is that official statistics of suicide rates may be an underestimate. As the ABS notes:

> ... for a death to be determined a suicide, it must be established by coronial enquiry that the death resulted from a ***deliberate act*** [emphasis added] of the deceased with the intention of ending his or her own life (intentional self-harm).[24]

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17 Australian Psychological Society (APS), Submission No 21, p 4.

18 BoysTown, Submission No 10, p 15; Diversity Health Institute, Submission No 10, p 7.

19 Inspire Foundation, Submission No 4, p 8.

20 Inspire Foundation, Submission No 4, p 8; Australian Suicide Prevention Foundation, Submission No 9, p 9.

21 Prof G Martin, Submission No 1, p 13; Inspire Foundation, Submission No 4, p 6.

22 Name Withheld, Submission No 8, p 1; BoysTown, Submission No 10, p 15.

23 See for example: Suicide Prevention Australia, Submission No 11, p 9; Mr C Gostelow, WA Department of Education, Transcript of Evidence, 31 January 2011, p 25.

24 ABS, *Causes of Death, Australia 2009* (2011), cat no 3303.0, p 25.

2.14 There is an inherent difficulty for coroners in determining the 'intent' of a deceased person, notwithstanding the fact that many people who suicide leave a record of their intentions. As a result, there may be some deaths which are suicides *as a matter of fact*, but insufficient evidence before the coroner precludes the finding of suicide *as a matter of law*.

2.15 ABS figures show that there are many deaths that occur as a result of 'mechanisms'[25] that are common in suicide, but where the element of intent differed or is unclear. For example, in 2009, 5,322 deaths were categorised as 'accidental', all of which were caused by 'mechanisms' common in suicide. Of these there were almost 1000 deaths registered as 'undetermined intent'.[26]

2.16 In addition, an ongoing issue for the ABS has been that the quality of the suicide data can be affected by the length of time required for the coronial process to be finalised and the coronial case to be closed. In the absence of a coronial finding, other conclusive evidence of intent (e.g. a suicide note), is required for a suicide to be recorded in the statistics. According to Suicide Prevention Australia, the accuracy of suicide data is questionable, and some experts suggest that the general rate of suicide may in fact be up to 16% higher than official figures.[27]

2.17 Other issues affecting the quality of data may be a reluctance to record a suicide due to the stigma attached to suicide, as well as recording/reporting variations between jurisdictions, including different standards of proof of intent and different coronial processes and a lack of systemic resourcing and training.[28] As pointed out during a roundtable hearing, with regard to coronial outcomes there are different approaches taken by different coroners which reflect competing but equally valid priorities, such as providing concrete findings to bereaved families, or leaving open findings in the absence of sufficient evidence.[29] However, it is abundantly clear that a complete picture of youth suicide in Australia (and suicide generally) will be hampered by systemically embedded under-reporting and by data collection differences across jurisdictions.

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25 Mechanisms common in suicide include hanging, strangulation or suffocation; poisoning by drugs or other methods including alcohol or carbon monoxide fumes; use of firearms; drowning; jumping from a high place.

26 ABS, *Causes of Death, Australia 2009* (2011), cat no 3303.0, p 29.

27 Suicide Prevention Australia (SPA), Submission No 11, p 9.

28 See for example: The Royal Australian & New Zealand College of Psychiatrists (RANZCP), Submission No 3, p 11; *headspace*, Submission No 14, p 4.

29 Mr S Phillips, Telethon Institute for Child Health Research, Transcript of Evidence, 15 February 2010, p 29.

2.18 Another important consideration raised frequently in evidence relates to the scope of data routinely collected and reported on. To develop a more complete understanding of the complex picture of youth suicide (and suicide generally), including identifying risk factors and emerging trends, and appropriately targeting services, contributors to the inquiry called for the routine collection of suicide data to include information on ethnicity, culture, geography and socio-economic status.[30] Presentation of aggregated data also limits the capacity for organisations to gain an understanding of the more complex picture of youth suicide.[31]

Committee Comment

2.19 It is clear that there is a range of information on suicide being collected by different organisations, with different collection and reporting standards. The Committee understands that the lack of a nationwide systematic approach limits the usefulness of suicide information. However, it is also evident that the issues associated with data collection and reporting of suicide, including youth suicide, are well recognised.[32] In relation to this, the Committee acknowledges that the ABS has already made significant efforts to implement reforms to improve the accuracy and quality of suicide data, and that these processes are ongoing.[33]

2.20 To address these issues, the *National Committee for the Standardised Reporting of Suicide* (NCSRS) was created by Suicide Prevention Australia with the support of the Australian Government Department of Health and Ageing (DoHA). The NCSRS aims include to 'achieve cross-jurisdictional and multi-party agreement on adequate, standard and operationalised criteria and reporting formats for suicide and related data.'[34] The NCSRS includes representative coroners offices, the NCIS, the ABS, the AIHW, DoHA, State and Territory Health Departments, police and crisis support services.

2.21 The Committee is also aware that the 2010 Senate report on suicide in Australia dealt extensively with the issue of suicide data collection and

30 See for example: RANZCP, Submission No 3, p 4; Diversity Health Institute, Submission No 12, p 6; Women's Health Victoria, Submission No 18, p 3.

31 See for example: Diversity Health Institute, Submission No 12, p 5; Women's Health Victoria, Submission No 18, p 3.

32 AIHW, Harrison JE, Pointer S and Elnour AA, *A review of suicide statistics in Australia. Injury research and statistics series no. 49* (2009).

33 Mrs A Schmider, ABS, Transcript of Evidence, 11 February 2011, p 4.

34 Suicide Prevention Australia's website, http://suicidepreventionaust.org/CurrentProjects.aspx, viewed on 13 April 2011.

reporting. The Senate report makes eight recommendations on these issues, including recommendations for governments, in consultation with the NCSRS, to improve the accuracy of suicide data and reporting.[35] The Committee supports the Senate report's recommendations in this regard, and is pleased to note the Government's positive response.

2.22 In addition to improved accuracy, the Committee considers that consideration should also be given to the scope of information collected, particularly social and demographic data which would assist with developing a better understanding of the complex picture of youth suicide, and suicide more broadly. The Committee also supports provision of more suicide data in disaggregated form.

Recommendation 1

2.23 **The Committee recommends that the National Committee for the Standardised Reporting of Suicide consider options for, and the feasibility of, extending the scope of social and demographic suicide data routinely collected and reported on, to include information on:**

- **ethnicity;**
- **culture;**
- **geography;**
- **educational attainment;**
- **employment status; and**
- **socio-economic status.**

Recommendation 2

2.24 **The Committee recommends that the National Committee for the Standardised Reporting of Suicide consider options for providing increased access to disaggregated suicide data.**

35 Parliament of Australia, Senate Community Affairs References Committee, *The Hidden Toll: Suicide in Australia* (June 2010). (See Recommendations 2-7, 21 & 28).

2.25 Of particular relevance to the issue of youth suicide, the Committee notes Recommendation 28 of the Senate report which calls for the ABS (and other relevant public agencies) to record and track suicides and attempted suicides in children aged under 15 years. As noted earlier in this Chapter, registered suicides in this group are relatively uncommon, though for a range of reasons it is likely that the reported figures are an underestimate. While acutely aware of the difficulties of establishing suicidal intent in this age group, and the extreme sensitivity for the families concerned, the Committee is keen to support initiatives which ensure that suicide in this demographic is not 'hidden'. The Committee believes that appropriate recognition of suicide in the under 15 year age group is needed to ensure that prevention initiatives do not neglect these children. The Committee notes that the Senate recommendation has been referred to the ABS.

Factors Affecting the Likelihood of Suicide

2.26 Understanding the factors that influence the likelihood of suicide will assist in developing strategies to reduce suicide rates. A significant body of research already exists which indicates that many factors contribute to the likelihood that someone will consider or attempt suicide.[36]

2.27 These factors generally act to either increase the likelihood of suicide (risk factors) or decrease this likelihood (protective factors). Risk and protective factors are also categorised according to the level at which they are present; that is *individual* factors, *social* and broad *contextual* factors. Figure 2.3 lists commonly cited risk and protective factors within each of the three categories.

36 See for example: Beautrais A, *Risk factors for suicide and attempted suicide among young people*, Australian and New Zealand Journal of Psychiatry, (2000), Vol 34, pp 420-36; Australian Government Department of Health and Ageing, *LIFE: Research and Evidence in Suicide Prevention* (2007), pp 12-23.

Figure 2.3 Examples of Suicide Risk and Protective Factors

	Risk factors for suicide	Protective factors for suicide
Individual	• gender (male) • mental illness or disorder • chronic pain or illness • immobility • alcohol and other drug problems • low self-esteem • little sense of control over the circumstances • lack of meaning and purpose in life • poor coping skills • hopelessness • guilt and shame	• gender (female) • mental health and wellbeing • good physical health • physical ability to move about freely • no alcohol or other drug problems • positive sense of self • sense of control over life's circumstances • sense of meaning and purpose in life • good coping skills • positive outlook and attitude to life • absence of guilt and shame
Social	• abuse and violence • family dispute, conflict and dysfunction • separation and loss • peer rejection • social isolation • imprisonment • poor communication skills • family history of suicide or mental illness	• physical and emotional security • family harmony • supportive and caring parents/family • supportive social relationships • sense of social connection • sense of self-determination • good communication skills • no family history of suicide or mental illness
Contextual	• neighbourhood violence and crime • poverty • unemployment, economic insecurity • homelessness • school failure • social or cultural discrimination • exposure to environmental stressors • lack of support services	• safe and secure living environment • financial security • employment • safe and affordable housing • positive educational experience • fair and tolerant community • little exposure to environmental stressors • access to support services

Source: *Australian Government Department of Health and Ageing, LIFE: Research and Evidence in Suicide Prevention (2007), p 14*

2.28 Risk and protective factors do not explain everything about suicide. Importantly, risk and protective factors operate differently in each individual, particularly as similar events in life will affect people in different ways. Although suicide is more frequent in individuals who exhibit multiple risk factors and few protective factors, the majority of people in this higher risk group do not attempt to take their own lives. In contrast, people with few or none of the risk factors might suicide. [37]

2.29 Risk and protective factors are also known to have greater or lesser influence in specific social and demographic groups. Among young

37 Australian Government Department of Health and Ageing, *LIFE: Research and Evidence in Suicide Prevention* (2007), p 14.

people some factors might be more influential. As noted by the SPA, transitions from childhood to adolescence and young adulthood are characterised by self-exploration, and acceptance (particularly by peers) is crucial to a robust sense of self worth.[38] Therefore factors that may increase the likelihood of young people feeling marginalised or socially isolated may be particularly important. Issues associated with sexual orientation, body image, bullying (including via social media) and learning difficulties may be particularly relevant to this group.[39] As noted by Lifeline Australia, another characteristic that may be more significant is that suicide among young people can sometimes be an impulsive act, which is not always thought through or planned.[40]

2.30 Importantly, as some factors are modifiable (such as drug use and alcohol abuse) they can be directly targeted by programs, and are fruitful areas for intervention. Other factors are non-modifiable (such as age or sex), but programs can nevertheless try to reduce the impact of these factors on an individual's likelihood of suicide.

Committee Comment

2.31 The Committee understands that there is a complex array of factors associated with suicide, and cautions against an overly simplistic view of youth suicide and its causes. Access to accurate and comprehensive data and an improved understanding of the influence of risk and protective factors on young people are needed to support an improved understanding. The Committee recognises however, that while this will assist the identification of populations or groups at increased risk of suicide, it will still not be possible to precisely identify individuals at risk, hence the need for early intervention strategies.

2.32 The Committee understands that the main value of this information is to provide a good evidence base to inform the development and appropriate implementation of strategies for reducing rates of youth suicide, and to enable effective evaluation of the impact of interventions. Current approaches to suicide prevention in Australia are considered in Chapter 3, including recently announced additional funding targeting suicide prevention.

38 SPA, Submission No 11, pp 10-11.

39 SPA, Submission No 11, pp 10-11.

40 Lifeline Australia, Submission No 2, p 10.

3

Interventions to Reduce Youth Suicide

3.1 This Chapter presents an overview of the various theoretical approaches to suicide prevention and early intervention. Australia's national policy response to youth suicide is examined and consideration given to recently announced of additional support for suicide prevention. The Chapter concludes by considering the importance of program evaluation and research to development and implementation of effective suicide prevention strategies.

Early Intervention Approaches

3.2 Early intervention programs may be grouped according to three very broad criteria: individual, group and universal.[1] An individual or 'indicated' intervention is one that treats individuals on the basis of a recognised risk factor (including previous suicidal behaviour). A group or 'selective' intervention focuses on specific groups and communities within society that have a higher risk of suicide. A 'universal' intervention is one that targets the entire population (or a segment of it), on the basis that there are some individuals within the population who may (eventually) be at risk of suicide, but who will not exhibit any risk factors (or these factors may not be identified by others). The universal approach is also important for increasing the general awareness of suicide risks and what can be done to help individuals at risk.

3.3 There are a number of national policies that affect the provision of early intervention programs: however, these programs are often developed and undertaken at a local or state level. Rather than trying to catalogue the

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1 Suicide Prevention Australia (SPA), Submission No 10, p 14.

existing programs across Australia, the following provides a summary of the general nature of types of programs. These are grouped by their approach – indicated, selective and universal. In general terms however, most interventions comprise a combination of elements aimed at reducing risk factors and promoting protective factors. It is equally important to recognise that risk and protective factors may be modifiable and non-modifiable.

Indicated Interventions

3.4 Indicated interventions are probably the most commonly understood methods of preventing suicide. This kind of intervention is aimed at reducing risk factors and promoting protective factors in an individual who has an identified risk factor(s). Such an intervention is not necessarily restricted to the individual concerned, but may include family, friends, colleagues, teachers and others.

3.5 Indicated interventions rely on the identification of individuals who are at risk; a limitation of this approach is that it will not provide assistance to individuals who are at risk but who cannot be identified. An additional barrier is so-called 'help-negation', where individuals in need avoid or withdraw from help.[2] This is particularly so in individuals experiencing depression.

3.6 Another limitation inherent in indicated interventions concerns the continuity of care, especially after a hospitalisation for a suicide attempt. As explained by Dr Matthews representing the Australian Psychological Society:

> We know that discharge from hospital after a suicide attempt is a very high risk time, and I believe we need protocols to support people at that time—the research suggests for up to 12 months.[3]

3.7 Individuals may also have disrupted care when they reach formal adulthood at the age of 18, which can have an impact on the availability of services. Particular discretion and care must be taken with those who are facing transition out of child and youth services into adult services, as this would be particularly distressing for individuals at risk of suicide.[4]

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2 Dr C Wilson, Submission No 17, p 1.

3 Dr R Matthews, Australian Psychological Society (APS), Transcript of Evidence, 20 April 2010, p 21.

4 BoysTown, Submission No 10, p 30.

Selective Interventions

3.8 Selective interventions generally involve a specific group whose members are at a higher risk of suicide. These groups are identified according to one or more underlying risk factors that all members share. As noted in Chapter 2, there are many groups within society that are considered to have a higher risk of suicide, although this does not mean that many or even any members of the group will necessarily contemplate suicide.

3.9 These groups include:

- Indigenous youth[5];
- young people from culturally and/or linguistically diverse or refugee backgrounds[6];
- gay, lesbian, bisexual, transgender and intersex young people[7];
- young people living in rural or remote parts of Australia[8];
- young people bereaved by suicide; and
- young people who have a mental illness or have previously attempted suicide or engage in self-harm.[9]

3.10 Selective intervention programs must be tailored to the particular group in question, in order to reflect a group's attitudes and beliefs about suicide, mental health and well being.[10]

3.11 These programs operate at different levels: some are nationwide and others local. As Suicide Prevention Australia (SPA) notes in its submission to the inquiry, such programs encompass:

> Community based, youth-friendly services, such as drop-in centres, recreational activities, sporting groups, school-based workshops or courses and outreach services that aim to increase at-risk young people's social connectedness and sense of belonging, reduce isolation, improve awareness, knowledge and attitudes towards suicide and mental health, build support

5 Billard Aboriginal Corporation, Submission No 16, p 2.

6 Diversity Health Institute, Submission No 12, p 1.

7 APS, Submission No 21, p 4.

8 Billard Aboriginal Corporation, Submission No 16, p 2.

9 SPA, Submission No 11, p 22.

10 See for example: Lifeline, Submission No 2, p 9; SPA, Submission No 11, p 2; Diversity Health Institute, Submission No 12, p 10; Billard Aboriginal Community, Submission No 16, p 6; Women's Health Victoria, Submission No 18, p 4; Ms H Jevons, Transcultural Mental Health Centre, Transcript of Evidence, 30 June 2010, p 13.

> networks and provide avenues for referrals to other services, where necessary. The involvement of youth, especially those with lived experience of suicide is crucial to informing programs and providing safe environments for at-risk youth to participate in beneficial activities and seek help.[11]

Universal Interventions

3.12 The title 'universal interventions' is perhaps misleading, because good universal approaches do not respond to a particular event or group characteristic – that is, they do not 'intervene' in a specific way. Rather, these programs are targeted at the entire population (particularly age-groups within that population) in order to make general improvements in the capacity of individuals to recognise and seek help for suicidal risk behaviour in themselves and others.

3.13 Suicide Prevention Australia (SPA) gives a good summary of how these programs work. Universal approaches:

> ... generally focus on promoting social and emotional wellbeing and creating an environment conducive to help seeking and access to services should they be necessary. School based programs promoting mental health, physical health and anti-bullying contribute to reducing suicide risk factors. Public health and awareness campaigns also have a role to play in youth suicide prevention, training gatekeepers to recognise suicide risk and how to provide appropriate help and referrals is shown to be effective in reducing suicide.[12]

3.14 Australia was one of the first countries to adopt a national approach with a specific focus on preventing youth suicide through the National Youth Suicide Prevention Strategy (NYSPS).[13] Although the NYSPS was evaluated in 2000[14], according to the SPA due to lack of data and the relatively short duration of operation, the evaluation was not able to report on the strategy's effectiveness and efficiency at reducing overall youth suicide rates or increasing their health and wellbeing.[15] An overview of Australia's suicide prevention activities is presented below.

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11 SPA, Submission No 11, p 23.

12 SPA, Submission No 15, p 7.

13 Prof G Martin, Submission No 1, p 15; SPA, Submission No 11, p 11.

14 Mitchell, Penny. *Valuing Young Lives: Evaluation of the National Youth Suicide Prevention Strategy*. Melbourne: Australian Institute of Family Studies, 2000.

15 SPA, Submission No 11, p 11.

This is followed by consideration of the critical importance of adequate data and program evaluation to the design and implementation of effective and efficient youth suicide prevention interventions.

National Youth Suicide Prevention Strategy

3.15 The first major Federal Government approach to youth suicide prevention was the *National Youth Suicide Prevention Strategy* (NYSPS), begun in 1995. The youth-oriented strategy funded numerous programs around Australia, with a wide variety of aims and methods including things such as training for general practitioners and community health workers[16], youth depression programs (including studying barriers to referral)[17], and an online youth mental health service.[18]

3.16 This strategy was formally in place until 1999, and between those years, $31 million was allocated to fund various programs around Australia.[19] In 2000, the Federal Government implemented a replacement strategy, the *National Suicide Prevention Strategy* (NSPS) with a broadened, all-age focus.

National Suicide Prevention Strategy

3.17 The current NSPS is a program under the Coalition of Australian Governments' (COAG) *National Action Plan on Mental Health 2006-2011*. According to the Australian Government Department of Health and Ageing (DoHA), NSPS funding amounts to $127.1 million between 2006-07 and 2011-12.[20] The overall objective of the NSPS is to reduce the incidence of suicide and self-harm, and to promote mental health and resilience across the Australian population. It comprises four key interrelated components. These are:

- the *LIFE Framework*, which sets an overarching evidence-based strategic policy framework for suicide prevention in Australia;

16 Prof G Martin, Submission No 1, p 1.

17 Prof G Martin, Submission No 1, p 6.

18 Inspire Foundation, Submission No 4, p 3.

19 Australian Government Department of Health and Ageing, *LIFE: A framework for prevention of suicide in Australia* (2007), p 8.

20 Australian Government Mental Health and Well Being website, http://www.health.gov.au/internet/mentalhealth/publishing.nsf/content/national-suicide-prevention-strategy-1, viewed on 15 April 2011.

- the *National Suicide Prevention Action Framework*, which provides a plan of activity and priorities for the NSPS;
- the *National Suicide Prevention Program* (NSPP), an Australian Government funded program dedicated to suicide prevention activities; and
- mechanisms to promote alignment with state and territory suicide prevention activities.

3.18 An important part of this strategy is the *Living Is For Everyone (LIFE): Framework*. It provides a suite of resources and research findings on how to address the complex issues of suicide and suicide prevention for academics, researchers, policy makers, health or community services professionals, service providers and community organisations. The *LIFE Framework* aims to:

- improve understanding of suicide;
- raise awareness of appropriate ways of responding to people considering taking their own life; and
- raise awareness of the role people can play in reducing loss of life to suicide.[21]

3.19 The *National Suicide Prevention Action Framework* has two primary functions. These are to:

- assist the Australian Suicide Prevention Advisory Council (ASPAC) to provide confidential advice to the Minister and DoHA on priorities and strategic directions; and
- to assist DoHA with implementation to the NSPP.

3.20 The NSPP provides funding for suicide prevention activities. It funds a range of community-based projects and national initiatives incorporating activities across the spectrum of suicide prevention interventions: indicated, selective and universal.

3.21 Although it is not feasible for this report to include a detailed examination of the full range of suicide prevention programs available, support is provided for a range of initiatives which target the health and well being

21 *LIFE Framework* website, http://www.livingisforeveryone.com.au, viewed on 2 June 2011.

of children, young people and their families.[22] Some of the larger, nation-wide programs include:

- Early Intervention Services for Parents, Children and Young People: which aims to support mental health promotion, prevention and early intervention for all children through universal evidence-based school and early childhood programs; and through targeted programs aimed at those children who are at highest risk of developing mental health problems, or who have early signs, symptoms or diagnosis of mental health problems;
- KidsMatter (Early Childhood and Primary) and MindMatters (Secondary): which provide social development education for primary and secondary school aged children respectively;[23]
- headspace: which provide youth friendly, community-based services established to promote and facilitate improvements in mental health, social well being and economic participation of young people; and
- Youth Connections: which provide individualised case management approach to assist eligible young people to remain engaged or re-engage them with education and/or further training, and to improve their ability to make positive life choices.

3.22 There is obviously great diversity between State and Territory jurisdictions' approaches to early intervention programs. Mechanisms to promote alignment are currently being progressed through the COAG *National Action Plan for Mental Health 2006–2011* and the *Fourth National Mental Health Plan 2009–14*.

Committee Comment

3.23 In view of the complex array of factors which influence a young person's risk of suicide and the difficulty of identifying at risk individuals, the Committee recognises that all three early intervention approaches are critical to tackling youth suicide. This is well illustrated by the account given in the submission from Professor Graham Martin which describes the stories of two girls: an individual obviously in danger of suicide who did not take her own life, and another individual with no apparent risk factors who did. In this scenario, while the girl who survived benefited

22 Australian Government Mental Health and Well Being website, http://www.health.gov.au/internet/mentalhealth/publishing.nsf/Content/children-and-youth-lp-1, viewed on 30 May 2011.

23 SPA, Submission No 11, pp 15-16.

from an individual approach provided by an indicated intervention, the girl who died could only have been helped through a universal approach.[24]

3.24 Evidence received both by the current Committee and its predecessor in the 42nd Parliament called for expansion of funding for programs at all levels of early intervention and increased access to services.[25] Again, the Committee acknowledges that the 2010 Senate Committee's report on suicide dealt extensively with the issue of programs and services, making 10 recommendations.[26] Recommendations called for increased support for programs and services for high risk groups including: men; Indigenous Australians; gay, lesbian, bisexual, transgender and intersex individuals; individuals who engage in self-harm or who have previously attempted suicide; individuals with mental illness; and individuals who have recently been released from correctional services.

3.25 Recommendation 23 of the Senate report also sought to improve access to non face-to-face services, including telephone and online counselling services. In December 2010, in its own discussion paper, the Committee took the opportunity to canvass the following policy proposals that had emerged during the course of the inquiry:

- the need for more frontline services including psychological and psychiatric services;
- additional support for communities affected by suicide;
- targeting those who are at greatest risk of suicide;
- promoting mental health and well being among young people;
- additional youth *headspace* sites; and
- additional Early Psychosis Prevention and Intervention Centres (EPPICs).[27]

3.26 In May 2011, announcements made as part of the 2011-12 Budget have provided a commitment to address many of the Senate report's

24 Prof G Martin, Submission No 1, pp 3-4.

25 See for example: Lifeline Australia, Submission No 2, pp 3-4; The Royal Australian & New Zealand College of Psychiatrists (RANZCP), Submission No 3, pp 7-8; *headspace*, Submission No 14, p 1.

26 Parliament of Australia, Senate Community Affairs References Committee, *The Hidden Toll: Suicide in Australia* (June 2010). (See Recommendations 23--27, 29, 30, 32-34).

27 Parliament of Australia, House of Representatives Standing Committee on Health and Ageing, *Discussion Paper for the Inquiry into Early Intervention Aimed at Preventing Youth Suicide* (December 2010).

recommendations for increased services and to implement the policy proposals outlined in the Committee's discussion paper. These are outlined briefly below.

Additional Support for Suicide Prevention Interventions

3.27 In the 2011-12 Budget, the Australian Government announced $1.5 billion to reform the nation's mental health services over five years. This builds upon the 2010 budget and election commitments totalling $624 million for the same five year period, including $443 million to tackle suicide. The DoHA portfolio budget statement for mental health states:

> In 2011-12, the department will also continue to implement program activities associated with the Government's commitment to prevent the tragedy of suicide and reduce its toll on individuals, families and communities.[28]

3.28 Announcements include measures to provide greater access to community-based psychological services for those who have attempted suicide, or who are at risk. This will be achieved through expansion of the Access to Allied Psychological Services (ATAPS) which will:

> ... target hard to reach areas and communities that are currently underserviced, such as children, Indigenous communities and socioeconomically disadvantaged communities.[29]

3.29 Increased access to ATAPS is supplemented by the establishment of a single portal for web-based mental health services, to provide easier access to evidence-based online psychological therapy and counselling to:

> ... assist individuals currently not accessing traditional face-to-face services, particularly those living in rural and remote communities, those isolated due to other causes, those for whom anonymity is a priority or those who prefer a non-clinical setting.[30]

3.30 To tackle disproportionately high suicide rates among Aboriginal and Torres Strait Islander people, Indigenous communities have been

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28 Budget 2011-12, *Budget Statements Department of Health and Ageing – Outcome 11 – Mental Health*, p 310.

29 Budget 2011-12, *Budget Statements Department of Health and Ageing – Outcome 11 – Mental Health*, p 312-3.

30 Budget 2011-12, *Budget Statements Department of Health and Ageing – Outcome 11 – Mental Health*, p 313.

identified as a priority under the $22.6 million for the *Supporting Communities to Reduce Risk of Suicide*. The package will:

> ... develop education and training resources, including online resources, to help Indigenous health and other workers to respond more effectively to Indigenous people at risk of suicide and to help local communities experiencing grief as a result of suicide.[31]

3.31 The commitment to provide better access to mental health services for children and young people includes additional Government funding (to be matched by contributions from State and Territory governments) for Early Psychosis Prevention and Intervention Centres (EPPIC).[32] Funding is also provided for 30 more headspace centres, as well as for additional support to enhance the support offered through existing centres.[33] The 2011-12 Budget includes funding to support an expansion and evaluation of the KidsMatter suite of initiatives as an integral part of universal intervention measures to promote good mental health and resilience in children and young people.[34]

Committee Comment

3.32 The Committee is pleased to note the significant additional support announced in the 2011-12 Budget for a range of programs and services to improve mental health and well being, including initiatives which target children and young people. Taking these recent announcements into account, the Committee understands that funding for suicide prevention has more than doubled since 2005-06.

3.33 In relation to youth suicide prevention, the Committee is encouraged by the broad range of early intervention approaches supported, including those which target at risk individuals and groups, as well as universal interventions which operate to promote good mental health and resilience for all young people. The Committee also believes that initiatives to facilitate access to telephone and online counselling services is likely to

31 Budget 2011-12, *Budget Statements Department of Health and Ageing – Outcome 11 – Mental Health*, p 316.

32 Budget 2011-12, *Budget Statements Department of Health and Ageing – Outcome 11 – Mental Health*, p 313.

33 Budget 2011-12, *Budget Statements Department of Health and Ageing – Outcome 11 – Mental Health*, p 313.

34 Budget 2011-12, *Budget Statements Department of Health and Ageing – Outcome 11 – Mental Health*, pp 314-5.

have particular appeal to young people, including young men who, after friends and family, are most likely to turn to the internet for support.[35]

3.34 The Committee notes that the majority of additional support will build on and extend existing programs and services, with implementation over several years. As such, it is likely to be some time before the outcomes of enhanced measures to reduce rates of youth suicide can be evaluated. Nevertheless, the Committee believes that evaluation of individual interventions, and of the strategic approach to suicide prevention, will be of critical importance. This issue is considered by the Committee in more detail below.

Research into Youth Suicide and Program Evaluation

3.35 A number of submissions to the inquiry argue that there is a need for additional support for research into the prevention of youth suicide.[36] In particular, some submissions compare the level of support for research into suicide with the level of support for research into breast and skin cancer. On the basis of this comparison they observe that although suicide accounts for similar mortality rates, it receives proportionately less support for research.[37] While some contributors to the inquiry identified specific areas for further research[38], in general terms, submissions identified the importance of research in providing new knowledge regarding causes of youth suicide and assessing new strategies for intervention.[39]

3.36 The need for research to ensure that services 'keep up' and do not rely too heavily on what has been available historically was also raised.[40] For example, Suicide Prevention Australia while highlighting the potential for internet and social-media-based interventions, point out that further research is needed to verify its efficacy.[41] Another research issue which was discussed at one of the roundtables was the challenge of translating

35 See for example: Lifeline Australia, Submission No 2, p 4; Australian Suicide Prevention Foundation, Submission No 17, p 11; BoysTown, Submission No 10, pp 13-14; SPA, Submission No 15, p 2; Dr C Wilson, Transcript of Evidence, 11 February 2011, p 38.

36 SPA, Submission No 15, p. 4.

37 Australian National University, Submission No 13, p 1.

38 Diversity Health Institute, Submission 12, p 8; Dr C Wilson, Submission No 17, p 1.

39 Australian National University, Submission No 13, p 1.

40 Youth Focus, Submission No 20, pp 6-7.

41 SPA, Submission No 11, p 34.

research outcomes into practice to improve intervention programs and enhance service provision.[42]

3.37 In addition to providing support for research, the importance of program evaluation was also frequently raised. As explained during roundtable discussions, there are significant difficulties in assessing whether or not strategies, or indeed interventions at program level, are effective. For example, although the implementation of the NYSPS was followed by a reduction in the annual rate of youth suicide over many years, there is no unambiguous evidence that shows implementation of the strategy was itself the cause. Where evaluations have been undertaken, evidence suggests that to some extent assessments have been hampered by a paucity of disaggregated statistical data on high risk groups.[43] Despite these difficulties, the importance of evaluation was frequently reiterated. A number of submissions supported a national approach to the evaluation of existing suicide prevention programs[44], with some even suggesting that a specific portion of all funding be directed towards evaluation.[45]

Committee Comment

3.38 The Committee understands that there is already a significant body of research on youth suicide. However, as data shows, patterns of youth suicide are not static over time. This suggests to the Committee that youth suicide rates are influenced by risk factors, which may be more prevalent or influential at particular times or in specific circumstances. Furthermore, there is also the possibility that new factors may emerge which influence rates of youth suicide. The emergence of new risk and protective factors is well illustrated by evidence that the Committee received relating to new mediums of communication (e.g. mobile phones, internet, social networking) and their prominence in the lives of young people. The Committee heard that new communication technologies can either be a positive or negative influence depending on the circumstances.[46] For example, while the internet can provide positive opportunities for young people to connect with peers and services, the issue of cyber-bullying has emerged which in some cases has led young victims to suicide. Another worrying trend is the emergence of internet sites which 'glamorise' or

42 Dr C Wilson, Transcript of Evidence, 11 February 2011, p 40.

43 Ms J Robinson, Orygen Youth Health Research Centre, Transcript of Evidence, 20 April 2010, p 37.

44 BoysTown, Submission No 10.1, p 2; SPA, Submission No 15, p 5.

45 RANZCP, Submission No 3, p 4.

46 SPA, Submission No 11, p 18.

promote suicide.[47] In this context, the Committee believes that there is a strong case to support sustained research so that the evidence base is continually updated such that emerging issues and changing trends can be identified and proactive responses developed.

3.39 The Committee is aware that the *Fourth National Mental Health Plan 2009–14* includes an action to develop a national mental health research strategy to develop and promote collaboration and develop research agenda. The Committee understands that research into suicide and suicide prevention will be considered as part of this strategy. The National Health and Medical Research Council (NHMRC) is the major funder of health and medical research in Australia. The Committee is pleased that in the 10 years since 2001-02, support for mental health research has increased from approximately $17.5 million to over $65 million in 2010-11.[48] The Committee understands that support for research is awarded across all disciplines on a competitive basis and according to the quality of research proposals as assessed by peer review. The Committee encourages youth suicide and suicide prevention researchers to apply for support through these standard competitive mechanisms.

3.40 However, the Committee is also of the view that that youth suicide warrants consideration as a priority issue for research. As such the Committee understands that in addition to support available through NHMRC standard processes, there are other avenues of support for research into youth suicide. The Committee is aware that support for social and behavioural research, including suicide research, is available from the Australian Research Council (ARC).[49] Research is also supported by government departments with a portfolio interest in youth, health and well-being such as DoHA, the Department of Education, Employment and Workplace Relations and the Department of Families, Housing, Community Services and Indigenous Affairs. Similarly, state and territory government departments and agencies with a portfolio interest also support research into youth suicide. The Committee notes that ASPAC has a key role in promoting and coordinating research activities.[50] Therefore the Committee recommends that ASPAC liaise with the NHMRC, the ARC, government departments and other agencies with a role in this

47 Lifeline, Submission No 2, p 8.

48 National Health and Medical Research Council (NHMRC) website, http://www.nhmrc.gov.au/grants/dataset/disease/mental.php, viewed on 7 June 2011.

49 Australian Government, Australian Research Council website, http://www.arc.gov.au/search/default.asp?qu=Suicide; viewed on 21 June 2011.

50 *LIFE Framework* website, ASPAC Communiqué, 2 March 2011 Meeting, http://www.livingisforeveryone.com.au/Communiqués-.html, viewed on 20 June 2011.

research domain, to develop a priority research agenda for youth suicide with a view to jointly supporting coordinated and targeted calls for research.

Recommendation 3

3.41 **The Committee recommends that the Australian Suicide Prevention Advisory Council liaise with the National Health and Medical Research Council, the Australian Research Council, government departments (including state and territory government departments) and other agencies with a role in this domain, to develop a priority research agenda for youth suicide, with a view to jointly supporting a coordinated and targeted program of research.**

3.42 Translation of youth suicide research findings to inform policy and the development of evidence-based best practice interventions and services is one issue that the Committee believes warrants further research. The Committee notes that the NHMRC offers funding under its *Partnership for Better Health* initiative to:

> ... improve the availability and quality of research evidence to decision makers who design policy and to inform the policy process by supporting more effective connections between the decision makers and the researchers.[51]

3.43 The Committee encourages youth suicide and suicide prevention researchers with an interest in translation to consider opportunities to increase collaboration with policy makers and service providers through the NHMRC's *Partnership for Better Health* initiative. The Committee encourages researchers interested in research translation to explore the opportunities for support through this mechanism.

3.44 With regard to existing youth suicide prevention measures, it is evident to the Committee that while there are many programs operating around Australia, there is no holistic evaluation of which programs work, which need alteration, and how effectively funding is being used.[52] Concerns about the evaluation of the NSPS specifically were raised with the

51 NHMRC website, http://www.nhmrc.gov.au/grants/partnerships/index.htm, viewed on 7 June 2011.

52 RANZCP, Submission No 3, p 4.

Committee. Examples of the comments made in relation to the NSPS include:

> The answer is that we do not know whether or not it has been effective. ... The strategy certainly paid lip service to the idea that evaluation needed to take place. They said they were going to fund a series of projects and that they expected them to be evaluated, but they were not evaluated—and whether they were resourced adequately in order to evaluate themselves properly is another question as well.[53]

3.45 The Committee believes that rigorous evaluation is critical to establishing a robust evidence base and was concerned by apparent deficiencies. Until the evaluation of suicide interventions across the board (including those directed at preventing youth suicide) are sufficiently stringent to ensure that programs are meeting stated needs and objectives, programs that are proving effective (including pilot programs with short term funding) will not be repeated across the country and sustained. Furthermore, programs that are ineffective may continue, diverting limited resources, and worse still, may actually do more harm than good. This lack of understanding significantly limits the ability of governments and others, including service providers, to design, resource and implement a full complement of effective youth suicide prevention programs.

3.46 The Committee notes the Senate report's recommendations for more research into suicide to be supported under the NSPP and for improved mechanisms to coordinate and disseminate research and best practice for suicide prevention.[54] The Committee believes that a rigorous and systematic approach to evaluation is essential. Therefore, the Committee is pleased to note that a comprehensive evaluation of the NSPP is due to commence mid 2011 and will:

> ... examine how effectively the NSPP has met its aims and objectives to date, and will set a framework for future evaluation including new activity under the 2011-12 Budget mental health reform package.[55]

3.47 The Committee also understands that a new *National Mental Health Commission* will be established to enhance accountability and transparency

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53 Ms J Robinson, Orygen, Transcript of Evidence, 20 April 2010, pp 36-37.

54 Parliament of Australia, Senate Community Affairs References Committee, *The Hidden Toll: Suicide in Australia* (June 2010). (See Recommendations 35 & 36).

55 Budget 2011-12, *Portfolio Budget Statement – Outcome 11 – Mental Health*, p 310.

in the mental health system. The Committee understands that one of the Commission's activities will be:

> ... to develop an annual national report card on mental health and suicide prevention, which will use the most current data to monitor mental health reform and summarise the mental health 'state of the nation'.[56]

3.48 The Committee believes that the outcome of evaluations should be shared broadly across the sector. The Committee strongly supports the Senate report's recommendation for the Commonwealth Government to create a suicide prevention resource centre to disseminate research and best practice. Building on this recommendation, the Committee believes that the Department of Health and Ageing could play a facilitative role, through the establishment and maintenance of an online program evaluation clearinghouse, with explicit measures of program success.[57] The Committee suggests that the Australian Institute of Suicide Research and Prevention, based at Griffiths University, would be well placed to host the facility.

Recommendation 4

3.49 **The Committee recommends the Department of Health and Ageing, in conjunction with state and territory governments, facilitate the sharing of evaluations of existing programs and youth-suicide research across the entire suicide-prevention sector, through the establishment and maintenance of an online program-evaluation clearinghouse.**

56 Budget 2011-12, *Portfolio Budget Statement – Outcome 11 – Mental Health*, p 314.

57 Mr A Woodward, Lifeline Australia, Transcript of Evidence, 11 February 2011, p 41.

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

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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 peers may be more challenging and require proactive dissemination

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.

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.

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

A

Appendix A – List of Submissions

1 Professor Graham Martin OAM
2 Lifeline Australia
3 The Royal Australian & New Zealand College of Psychiatrists
3.1 The Royal Australian & New Zealand College of Psychiatrists *(Supplementary)*
4 Inspire Foundation
5 Confidential
6 Sunny Kids
7 Bush Venture P/L
8 Name withheld
8.1 Name withheld *(Supplementary)*
9 Australian Suicide Prevention Foundation
10 BoysTown
10.1 BoysTown *(Supplementary)*
11 Suicide Prevention Australia
12 Diversity Health Institute
13 Centre for Mental Health Research, Australian National University
14 headspace
15 Suicide Prevention Australia
16 Billard Aboriginal Corporation
17 Dr Coralie Wilson PhD MAPS
18 Women's Health Victoria
19 Commissioner for Children and Young People, Western Australia
20 Youth Focus Inc
21 The Australian Psychological Society Limited
22 Australian Government Department of Education, Employment & Workplace Relations
23 Mental Illness Education ACT
24 Australian Government Department of Health & Ageing
25 Police Federation of Australia

B

Appendix B – List of Exhibits

1 Provided by Fremantle *headspace*
Information about Headspace Fremantle, including: service delivery and statistics.

2 Provided by Youth Focus
Organisational information including: newsletter, statistics and progress report from July-December 2009.

3 Provided by Telethon Institute for Child Health Research
Presentation on completed suicides of Western Australians: a psychological autopsy study.

4 Provided by Fremantle headspace
Headspace Final Evaluation Report.

5 Provided by Professor Graham Martin OAM
Krysinka K *et al* (2009), *Identity, Voice, Place: Suicide Prevention for Indigenous Australians - A Social and Emotional Wellbeing Approach.*

6 Provided by Professor Graham Martin OAM
Martin G *et al* (2008), *Final Report: Australian National Epidemiological Study of Self Injury (ANESSI).*

7 Provided by Professor Graham Martin OAM
Martin G *et al* (2009), *National Suicide Prevention Strategies: A Comparison.*

8 Provided by Inspire Foundation
Christensen H *et al* (2009), *E-Mental Health: A 2020 Vision & Strategy for Australia.* (Related to Submission 4)

9 Provided by MindSavers
Flow Chart*: Proposed 'youth directed' mental health strategy.*

10 Provided by Name Withheld
House of Representatives (Main Committee) Official Hansard Transcript from 2 October 1997 pp 9162– 9163.

11 Provided by Bush Venture P/L
'Champ Camp' Concept of Operations Executive Summary. (Related to Submission 7)

12 Provided by Bush Venture P/L
Book by Mr John Guy, *Dragons Teach Wisdom.* (Related to Submission 7)

13 Provided by Australian Suicide Prevention Foundation
Sample correspondence received by ASPF - website usage statistics for 'HOLD ON to life'. (Related to Submission 9)

14 Provided by BoysTown
BoysTown Strategy and Research Team (2009), *Mentor One Evaluation (Summary).* (Related to Submission 10)

15 Provided by BoysTown
BoysTown social inclusion model flow chart. (Related to Submission 10)

16 Provided by BoysTown
2008 Parentline Evaluation Executive Summary. (Related to Submission 10)

17 Provided by BoysTown
BoysTown Response to the National Advisory Council on Mental Health Discussion Paper March 2010. (Related to Submission 10)

18 Provided by Suicide Prevention Australia
Table: intervention activities and level of evidence. *(*Related to Submission 11)

19 Provided by the Australian National University, Centre for Mental Health Research
Delivering timely interventions: the impact of the internet on mental health. Medical Journal of Australia, Volume 192, No 11. (Related to Submission 13)

20 Provided by Wesley Mission
The Wesley Report Number 7 (May 2010), *Keeping minds well: Mental health is everybody's business.*

21 Provided by Inspire Foundation
Inspire Foundation consultation with young people (June 2010).

22 Provided by Billard Aboriginal Corporation
Speech by Mary O'Reeri 17th August 2009 at National Museum, Canberra, ACT. (Related to Submission 16)

23 Provided by Billard Aboriginal Corporation
WA Legislative Council 10th September 2009, Transcript of debate comprising statements by Hon Helen Morton (11:06am to 5.27pm). (Related to Submission 16)

24 Provided by Dr Coralie Wilson
Copyright Regulations 1969. (Related to Exhibit 25)

25 Provided by Dr Coralie Wilson
Wilson C *et al* (2011), *Early access and help seeking. practice implications and new initiatives.* (Related to Submission 17)

26 Provided by Mental Illness Education ACT
Savigny J (2008), *Stories changing minds: inside mental illness education ACT.*

27 Provided by Mental Illness Education ACT
Rickwood D *et al* (2004), *Educating young people about mental health and mental illness: evaluating a school-based programme.* International Journal of Mental Health Promotion, Volume 6, Issue 4, pp 23–32.

28 Provided by Mental Illness Education ACT
Read S *et al* (2009), *Volunteering as a community mental health educator: positives and negatives for recovery.* Australian e-journal for the Advancement of Mental Health, Volume 8, Issue 2, pp 1–9.

29 Provided by Mental Illness Education ACT
MIEACT Policy: Principle of Doing No Harm.

30 Provided by Inspire Foundation
Inspire Foundation and NSW Department of Education and Training. *Promoting youth mental health in personal development, health and physical education: 2008 Evaluation Report.*

31 Provided by Dr Coralie Wilson
Wilson C *et al* (2007), *Depressive symptoms and help-seeking intentions in young people.* Clinical Psychologist, Volume 11, No 3, pp 98–107. (Related to Submission 17)

32 Provided by Dr Coralie Wilson
Deane F *et al* (2001), *Suicide ideation and help negation: not just hopelessness or prior help.* Journal of Clinical Psychology, Volume 57(7), pp 901-914. (Related to Submission 17)

33 Provided by Dr Coralie Wilson
Rickwood D *et al* (2007), *When and how do young people seek professional help for mental health problems.* Medical Journal of Australia, Volume 187, No 7, S35–39. (Related to Submission 17)

34 Provided by Dr Coralie Wilson
Rickwood D *et al* (2005), *Young people's helpseeking for mental health problems.* Australian e-journal Advancement of Mental Health, Volume 4, Issue 3, Supplement. (Related to Submission 17)

35 Provided by Dr Coralie Wilson
Wilson C (2010), *General psychological distress symptoms and help-avoidance in young Australians.* Advances in Mental Health, Volume 9, Issue 1, pp 63 – 72. (Related to Submission 17)

36 Provided by Dr Coralie Wilson
Wilson C and Deane F (2001), *Adolescent opinions about reducing help-seeking barriers and increasing appropriate help engagement.* Journal of Educational and Psychological Consultation, Volume 12, Issue 4, pp 345-364. (Related to Submission 17)

37 Provided by Dr Coralie Wilson
Wilson C and Deane F (2010 in press), *Brief report: need for autonomy and other perceived barriers relating to adolescents' intentions to seek professional mental health care.* Journal of Adolescence. (Related to Submission 17)

38 Provided by Dr Coralie Wilson
Wilson C and Deane F (2010), *Help-negation and suicidal ideation: the role of depression, anxiety and hopelessness.* Journal of Adolescence, Volume 39, pp 291-305. (Related to Submission 17)

39 Provided by Dr Coralie Wilson
Wilson C *et al* (2005), *Can hopelessness and adolescents' beliefs and attitudes about seeking help account for help negation?* Journal of Clinical Psychology. (Related to Submission 17)

40 Provided by Dr Coralie Wilson
Wilson C *et al* (2008), *Reducing adolescents' perceived barriers to treatment and increasing help-seeking intentions: effects of classroom presentations by General Practitioners.* Journal of Youth Adolescence, Volume 37, pp 1257-1269. (Related to Submission 17)

41 Provided by Dr Coralie Wilson
Wilson C *et al* (2010), *Adolescents' suicidal thinking and reluctance to consult General Medical Practitioners.* Journal Youth Adolescence, Volume 39, pp 343-356. (Related to Submission 17)

42 Provided by Dr Coralie Wilson
Deane F *et al* (2007), *Brief report: impact of classroom presentations about health and help-seeking on rural Australian adolescents' intentions to consult health care professionals.* Journal of Adolescence, Volume 30, pp 695-699. (Related to Submission 17)

43 Provided by Dr Coralie Wilson
Wilson C and Deane F (2010), *Predicting adolescents' future intentions to seek help for mental health problems.* Youth Studies Australia, Volume 29, Number 4, pp 27-33. (Related to Submission 17)

44 Provided by Dr Coralie Wilson
Cartmill T *et al* (2009), *Gatekeeper training for youth workers: Impact on their help-seeking and referral skills.* Youth Studies Australia, Volume 28, Number 1, pp 5-12. (Related to Submission 17)

45 Provided by Dr Coralie Wilson
Wilson C *et al* (2011), *Early access and help seeking: practice implications and new initiatives*. Early Intervention in Psychiatry, Volume 5, Supplement 1, pp 34-39. (Related to Submission 17)

46 Provided by Department of Health (Western Australia)
Coronial Report WA February 2008. Inquests into deaths of various people.

47 Provided by Department of Health (Western Australia)
Record of investigation of death 2008: Oombulgurri findings.

48 Provided by Department of Health (Western Australia)
The Age (4 July 2008), *Aboriginal suicide rates at crisis point.*

49 Provided by Australian Government Department of Health and Ageing
Andersen K et al (2010), *Suicide in selected occupations in Queensland: evidence from the State suicide register.* Australian and New Zealand Journal of Psychiatry, Volume 44, pp 243-249. (Related to Submission 24)

C

Appendix C – List of Roundtable Forums and Briefing

43rd Parliament

Monday, 31 January 2011 - Perth

Centrecare

Ms Melissa Perry, Executive Manager

Department of Education (Western Australia)

Mr Christopher Gostelow, Manager, School Psychology Service

Department of Health (Western Australia)

Ms Anna Sinclair, Manager, State-wide Policy & Strategy, Office of Aboriginal Health

Inspire Foundation

Ms Cassie Endris, Youth Ambassador
Mr Aram Hosie, State Manager (WA)

KidsMatter Primary

Mr Stephen Macdonald, State Coordinator

Mentally Healthy WA

Prof Robert Donovan, Principal Director
Miss Stephanie Francas, Health Promotion Officer

Principals Australia

Ms Tracy Zilm, MindMatters National Training Coordinator

Statewide Indigenous Mental Health Service

Mr Michael Mitchell, Program Manager

West Australian Football Commission

Mr Dale Ballantyne, Country Development Manager
Mr Wayne Bradshaw, Chief Executive

Western Australian Secondary School Executives Association

Mr Robert Nairn, President

Western Australian General Practice Network

Ms Lin Holker, Clinical Liasion Coordinator, ALIVE, Perth Primary Care Network

Youth Affairs Council of Western Australia

Mr Craig Comrie, Executive Officer
Ms Olivia Knowles, Project Officer

Youth Focus

Ms Jennifer Allen, Chief Executive Officer
Mr Jonathan O'Neill, Team Leader

Friday, 11 February 2011 - Canberra

Private Capacity

Dr Coralie Wilson PhD MAPS

ACT Department of Education & Training

Mr Satish Singh, Assistant Manager

ACT Health

Dr Denise Riordan, Clinical Director, Child & Adolescent Mental Health Services
Dr Johann Sheehan, Suicide Prevention Policy Officer, Mental Health Policy Unit

Australian Air Force Cadets

Group Captain Kenneth Given, National Commander

Australian Bureau of Statistics

Mr Krystian Sadkowsky, Advisor, Mortality Statistics
Mrs Anneke Schmider, Director, Social and Demographic Statistics Branch

Australian Sports Commission

Mr Phil Borgeaud, Acting Director
Mrs Kirsten Peterson, Sports Psychologist

Australian Government Department of Education, Employment & Workplace Relations

Mr Don Mackenzie, Director, Office for Youth, Social Policy and Economics Strategy Branch

Australian Government Department of Health and Ageing

Ms Georgie Harman, First Assistant Secretary, Mental Health & Chronic Disease Division
Ms Colleen Krestensen, Assistant Secretary, Mental Health & Suicide Prevention Programs Branch

Lifeline Australia

Ms Susan Beaton, National Advisor on Suicide Prevention
Mr Alan Woodward, General Manager, Social Policy, Innovation Research & Evaluation

Mental Illness Education ACT

Miss Sophie Attridge, Volunteer Educator
Ms Pam Boyer, Executive Officer

Scouts Australia - ACT Branch

Mrs Margaret Hancocks, Region Commissioner, Hindmarsh

42nd Parliament

Monday, 15 February 2010 – Perth

Fremantle headspace

Mr Raffael di Bartolomeo, Clinical and Services Manager

OZHELP (WA)

Mr Julian Gimpel, Executive Officer

Telethon Institute for Child Health Research

Mr Shawn Phillips, Executive Officer, Ministerial Council for Suicide Prevention

Youth Focus Inc

Mrs Jennifer Allen, Chief Executive Officer
Ms Nicole Marshall, Acting Family Services Manager
Ms Amanda-Jane Moore, Business Development Manager

Tuesday, 20 April 2010 - Melbourne

beyondblue

Ms Judy Finn, Program Director, Public Health
Dr Brian Graetz, Program Director, Education & Early Childhood

headspace: National Youth Mental Health Foundation

Professor Helen Milroy, Board Member
Mr Chris Tanti, Chief Executive Officer

Inspire Foundation

Ms Michelle Blanchard, Senior Research Officer

MindSavers

Miss Rachel Baldwin, Youth Advocate
Dr Deborah Selway, Director

Orygen Youth Health Research Centre

Ms Joanna Robinson, Research Fellow

The Royal Australian and New Zealand College of Psychiatrists

Ms Teri Snowdon, Director of Policy
Dr Darryl Watson, Member of Executive

The Australian Psychological Society

Dr Rebecca Mathews, Manager, Practice Standards and Resources

Wednesday, 30 June 2010 - Sydney

Black Dog Institute

Miss Liza Culleney, Project Manager, Youth Initiatives
Mr Matthew Johnstone, Creative Consultant and Youth Program Developer

BoysTown

Ms Philippa Hawke, Senior Researcher, Strategy and Research Unit
Mr Michael Starr, Regional Manager

Australian National University, Centre for Mental Health Research

Professor Helen Christensen, Director

Inspire Foundation

Dr Philippa Collin, Managing Director of Research, Policy and Sector Engagement
Ms Mareka Newey, Youth Ambassador (Volunteer)

Jesuit Social Services

Mr Brendan Fitzgerald, Support After Suicide

Lifeline Australia

Mr Alan Woodward, General Manager, Social Policy Innovation Research & Evaluation

Suicide Prevention Australia Inc

Dr Michael Dudley, Chair
Mr Atari Metcalf, Board Member

SunnyKids

Mr Chris Turner, Chief Executive Officer

Transcultural Mental Health Centre

Ms Helen Jevons, Research Project Officer

Wesley Mission

The Reverend Dr Keith Garner, Superintendent/Chief Executive Officer
Mrs Annie Rogers, Area Manager West, Nepean Adolescent and Family Services