

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

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

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 youth⁵;
- young people from culturally and/or linguistically diverse or refugee backgrounds⁶;
- gay, lesbian, bisexual, transgender and intersex young people⁷;
- young people living in rural or remote parts of Australia⁸;
- 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 (NYSPPS).¹³ Although the NYSPPS was evaluated in 2000¹⁴, 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.

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* (NYSPPS), 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 workers¹⁶, 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* (NSPPS) with a broadened, all-age focus.

National Suicide Prevention Strategy

- 3.17 The current NSPPS 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), NSPPS funding amounts to \$127.1 million between 2006-07 and 2011-12.²⁰ The overall objective of the NSPPS 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, nationwide 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 underserved, 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

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 research³⁸, 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 programs⁴⁴, 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

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.