The Australian Medical Association (AMA) is the peak professional organisation representing medical practitioners in Australia. The AMA welcomes the opportunity to provide a submission to the Senate Community Affairs Reference Committee's Inquiry into Suicide in Australia.

Suicide is a significant public health issue in Australia. In 2007 suicide was ranked 15th as a cause of deaths registered in Australia (and the 10th leading cause of male deaths).[1] It has also been suggested that the incidence of suicide is higher than the number of registered suicides as the intent of deaths by drowning, drug overdose and single vehicle accidents can be difficult to determine. [2]

Medical practitioners have a significant role in suicide prevention, including the identification of risk, early intervention and providing care and referral to those who may have suicidal intentions. Doctors also provide care to as those people who have been bereaved by suicide.

It appears that there has been some reduction in Australia's suicide rate (age standardised suicide rate in 2007 was 8.9 per 100,000 standard population, compared with a rate of 14.3 per 100,000 standard population in 1998). [3] However there is further scope for improvement, particularly in a number of the at-risk population groups.

Evidence suggests that rather than focusing on individuals who are at risk of suicide, it is preferable to focus on at-risk population groups. [4] While it is not feasible to provide comment on all of the population groups deemed to be at high (er) risk of suicide, the following material will provide comment on a number of the population sub-groups that the AMA considers to be particularly important. These are: young people, the elderly, junior doctors, those living in rural and remote areas and Indigenous Australians.

High(er) risk groups

Young People

Young people are often considered to be healthy and in the 'prime' of their life, and in many instances their physical health is good. However, recent surveys suggest that young people experience high levels of psychological distress [5, 6] Unfortunately suicide is the leading cause of death for those aged 15 through to 24 years in Australia. [7] This appears to be consistent with international trends. [8, 9]

Youth suicide is a tragedy that affects not only the individual but also family, peers and the larger community and is often experienced as a personal failure by those who were in contact with the young person. [10] While families, friends and the medical community may never know the exact reasons, or thinking behind youth suicide, there are a number of common underlying 'drivers' or risk factors that have been identified. These include (but are not limited to) factors such as:

- Arguments and relationship breakdowns;
- Behavioural and disciplinary problems;

- Childhood abuse;
- Chronic family conflict and violence;
- Contagion suicide; and
- Mental health issues. [11]

Such diverse risk factors highlight the need for a range of social support services, not solely focused on suicide prevention, but rather on a wide range of issues which aim to assist young people who are experiencing difficulties.

There are also protective factors, which improve resilience in young people, allowing them to adapt and respond positively to adversity. There are a number of school based programs that aim to improve resilience in children and young people (such as MindMatters). [12] Medical practitioners may also be involved in providing outreach care to children and young people, via initiatives such as GPs in Schools and Dr Yes. [13]

While improving resilience may reduce the risk of suicide and psychological distress in some young people, it is also true that a range of mental health issues and disorders present during adolescences and young adulthood. While not everyone who has a mental illness attempts suicide, and not all of those who commit suicide have an established mental illness, it is clear that mental illness and suicidal thoughts, attempts and completed suicides are related. [14]

Young people who do decide to seek medical care / advice for mental health (and other health) problems /concerns, may face a range of real and perceived barriers, preventing or delaying their access to appropriate medical care. This is a problematic situation as general practitioners are highly trained and well placed to provide support to young people who are experiencing suicidal thoughts, or who are at risk of attempting suicide. The AMA believes that more should be done to encourage young people to seek support / advice from their general practitioners, if they have any health problems, including mental health and suicide related concerns.

Recommendations:

- *Real and perceived barriers to general practice experienced by young people need to be addressed;*

- *Young people should be encouraged to have an ongoing medical relationship with a general practitioner, acknowledging that continuous, comprehensive care may improve a doctor's ability to identify young people who are at risk of suicide;*

- *All medical practitioners, particularly GPs, should be offered enhanced education and training on adolescent health, including mental health and suicide risk.*

The Elderly

The Report *Ageing and Suicide*[15] notes that people aged over 65, males in particular, have rates of completed suicide that are higher than the rates of attempted suicide. In 2007, males aged over 85 had the highest age-specific suicide death rate (though this number is inflated by the small size of the population group).[16] This suggests that a suicidal act in the elderly is more likely to end in death. Suicide in the elderly is often overlooked and as such there is paucity of research in the area.

There appears to be a range of risk factors which may assist in identifying those elderly people who may be at risk of suicide. These factors include (but are not limited to):

- Physical illness (severity and number of);
- Social isolation;
- Loss (such as declining physical health, reduced carer support, bereavement particularly of a partner, marital breakdown);
- Financial difficulties; and
- Mental health problems / disorders.

These risk factors may be exacerbated by a general reluctance to speak about such issues. [17]

Elderly people are likely to have an established relationship with medical practitioners, including a general practitioner. This offers a significant opportunity for suicide prevention, including the identification of those elderly people who may be at an increased risk of suicide. Once a risk has been identified it is essential that there are age-appropriate follow up services to which doctors can refer their elderly patients.

It has also been suggested that the elderly often choose more lethal means of suicide.[18] More broadly restricting the availability of means to suicide has been linked to significant reductions in suicide rates. [19] Research on the impact of gun law reform in Australia, following an event in Port Arthur in 1996, showed a significant decline in suicides using firearms and no evidence that alternative methods had been substituted.[20] This prevention strategy does have limitations though, as the most common method of suicide in Australia at present is hanging, which is a difficult method to restrict access to. [21]

Recommendations:

- *Awareness raising among all medical professionals needs to be undertaken to highlight the risk of suicide in the elderly;*

- *Age-appropriate follow up services for those elderly people who are deemed to be at risk of suicide need to be established;*

- *Ongoing attention needs to be given to reducing access to the means of suicide.*

Junior Doctors
Doctors are often physically healthier than the average person. However, doctors tend to have psychological vulnerabilities and stresses that may increase the likelihood of depression (among other things such as drug and alcohol abuse).[22] Some suggest this is because of the stresses of the job (such as long working hours), while others point towards the personality traits of doctors.[23] [24] Regardless of the reason, or combination of reasons, it is an issue that requires attention.

The early years of a medical career can be physically and emotionally demanding. While doctors' health advisory services exist in most states and territories to support medical practitioners, junior doctors are a sub-group of the medical profession who may be at increased risk of poorer health.[25] The AMA's Council of Doctors in Training has been concerned about the health and wellbeing of junior doctors for some time and has facilitated a survey on the health and wellbeing of junior doctors in order to raise awareness of the issue and record baseline data.

The Survey covers issues such as self care, access to general practitioners, self medication and prescription, work life balance, stress and burnout and coping strategies. Of concern, the survey found that more than two thirds of respondents [26] had experienced high levels of stress at work and that nearly three quarters had been concerned about their physical and mental health in the previous year. [27]

While it is appropriate to encourage junior doctors to improve their practices of self care, the AMA believes more research in this area is required, so that there can be a better understanding of the situation. The AMA has expanded its policies to incorporate advocacy that encourages a better understand of suicide not only among junior doctors, but all medical practitioners.

Recommendations:

- *State and Territory Doctors Health Advisory Services should be funded to establish a research (epidemiological) database of doctors and medical students at risk of suicide and completed suicide (this information and data should be de-identified);*

- *There needs to be funding of systematic research on coronial and other reports of completed suicides of doctors and medical students to ensure that system failures are identified and rectified.*

Those Living in Rural and Remote Areas
In Australia, rates of suicide and suicide attempts are higher in rural and remote populations [28] with very remote regions having suicide rates more than double that of major capital cities.[29]

It has been suggested that 'community spirit' and the communal nature of rural areas may function as a protective factor for those at risk of suicide. [30] Despite this, social

stigma appears to be a major inhibiting factor to seeking help in rural and remote communities among those who are suicidal. In addition to social stigma, other risk factors include (but are not limited to):

- Economic and financial hardship;
- Easier access to means of suicide;
- Geographic and social isolation; and
- Reduced access to support services. [31]

Rural and remote communities may also have a shortage of health care facilities and have difficulties attracting and retaining health care professionals, including general practitioners. This is concerning as general practitioners may be the first and sometimes the only provider of mental health services in these rural and remote areas.[32] Support for general practitioners who operate in this environment is essential.

It is unlikely there will be a single solution to the issue of suicide in rural and remote communities, and a range of interventions is therefore warranted. Given the higher rates of suicide and suicide attempts, it is important that serious efforts are focused on reducing suicides and suicide attempts in rural and remote communities. Dr Graham Fleming's thesis 'Approach to Suicide'[33] provides evidence that the situation can be improved. Dr Fleming was able to show a statistically significant reduction in suicides and suicide attempts from the application of four main approaches to suicide prevention, including community education, building social capital and community capacity, emphasising early identification and intervention, as well as establishing a community child and adolescent health program, based in a local school with strong links to local medical practitioners.

Recommendations:

- *Practical support for general practitioner who work in rural and remote communities, and who are likely to be the only provider of mental health services locally. This support should include:*
    - *increased opportunities for education and professional development on issues of rural and remote suicide;*
    - *a database of risk factors and recall system for patients considered at risk of suicide;*
    - *professional and peer support programs for general practitioners, with a special focus on those general practitioners who are likely to be sole provider of mental health services in smaller rural and remote communities;*

- *Suicide prevention activities need to be adaptable to the needs of local communities, including the mechanisms for identification and early intervention for those at risk of suicide;*

- *More focus needs to be given to raising community awareness of suicide in rural and remote communities as well a focus on individual capacity building.*

Indigenous Australians

Suicide among Australia's Indigenous population is significantly higher than the general population. In some Indigenous population groups the suicide rate can be as much as 40% higher than the Australian population as a whole. [34] The AMA's 2009 Aboriginal and Torres Strait Islander Report Card, *The Health of Indigenous Males: Building Capacity, Securing the Future*, highlights concerning trends, such as that during 2006-7 Indigenous males were hospitalised for non fatal intentional self harm at a rate 2.9 times the rate of non-Indigenous males.[35]

As with other population groups who are deemed to be at increased risk of suicide, Indigenous people may encounter a range of risk factors which may contribute to higher rates of suicide. These include (but are not limited to):

- A range of environmental risk factors, such as: poverty, low socio-economic status, lack of education, poor employment status, living in rural and remote communities, domestic violence and abuse and drug and alcohol abuse;
- Being personally affected by suicide (within both the family and within the broader community);
- Trauma and grief associated with past discrimination, dislocation and mistreatment;
- Loss of cultural identity and isolation;
- Higher rates of incarceration;
- Lack of access to culturally appropriate services, and
- Poor health status. [36]

Some argue that the link between Indigenous suicide and mental health problems is less clear than for the rest of the Australian population. But due to a lack of specific research it is difficult to draw any clear conclusions on this. [37] What is known is that Indigenous people have a holistic understanding of wellbeing that incorporates health (mental and physical) as well as social, cultural and spiritual dimensions. This influences not only the wellbeing of the individual, but also the wellbeing of the broader community.

As cultural protocols may vary from community to community, population-based suicide prevention efforts need to maintain high levels of cultural sensitivity and adaptability. At the individual level, ensuring that Indigenous people have access to culturally appropriate primary health services is essential.

Recommendations:

- *Improved access to culturally appropriate suicide prevention programs and capacity building within Indigenous communities;*

- *A broad range of social support and community based services which address Indigenous disadvantage, including suicide risk;*

- *Further research into Indigenous health, including mental health and suicide;*

- *Improved access to culturally appropriate suicide prevention programs, and*

- *Improved access to primary health care.*

The Role of the Doctor
About 88% of Australians visit a general practitioner at least once a year, [38] resulting in significant opportunities to undertake suicide prevention opportunistically and identify and care for those Australians who are depressed and / or who may be at risk of suicide. While current evidence supports a focus on at-risk population groups, rather than individuals who may be at risk, medical practitioners are likely to encounter individuals who are at risk and will need to provide care to those people immediately.

A range of sources indicate that those who commit suicide are likely to have seen a general practitioner in the weeks and months prior to suicide. [39] [40] Unfortunately it seems that these patients rarely volunteer their intention and are likely to present with a seemingly unrelated physical health problem. [41] Additionally, evidence does not support routine screening of all patients for suicide risk. [42] The increasing demands on general practitioners may further undermine efforts to engage with those patients who are at risk of suicide.

Some of the population groups that are most at risk of suicidal thoughts, attempts and completed suicides, such as young people, are under represented in general practice patient populations. Whatever the reason, targeted efforts should be made to normalise and reinforce the value of routine doctor attendance. This could include targeted public awareness campaigns and enhancements to outreach initiatives such as the Youth Friendly Doctor program and Dr YES.

General practitioners are not the only medical practitioners who will come into contact with those individuals who have suicidal thoughts and attempts. Doctors who work in outreach services, as well as psychiatry and emergency medicine specialists are likely to come into contact with suicidal individuals. These interactions may require the provision of fairly unique care, nevertheless, it is important that these medical practitioners are well supported in their roles.

Recommendations:

- *Outreach and school based mental health programs need to ensure that they have strong linkages with local GPs;*

- *Efforts to encourage at-risk population groups to have their own general practitioner, via targeted public awareness campaigns and enhancements to outreach programs, need to be undertaken*

Follow up services
Medical practitioners are well placed to identify and assist those individuals who are at risk of suicide. However this activity relies heavily on the availability of speciality follow up services (acute and outpatient) that the patient may be referred to.

Specialised out-patient and acute care services need to be immediately available to ensure patient safety. Any delays or problems with accessing these services may undermine the initial efforts to prevent suicide. Such services need to be well funded and in some instances expanded to ensure availability for those patients who require them.

Lack of Supported Accommodation
While there has been a general improvement in services for people who are at risk of suicide, the lack of supported accommodation is a significant issue of concern to the medical profession. Those people who are receiving (acute or inpatient) mental health care for suicidal risk, thoughts and attempts, may improve in this managed environment. However, if these individuals are forced to return to a dysfunctional home and family environment due to a lack of other accommodation options, particularly supported accommodation, any progress or improvements can be quickly undermined.

The accommodation services needed to support people through this transition are often unable to meet the demand, making referrals by treating medical practitioners difficult. Medical practitioners also do not have the information, resources and time to arrange appropriate accommodation for their patients.

Recommendations:

- *Ongoing investment in follow up care for those at risk of suicide needs to be made in order to ensure appropriate services are available in a timely manner for those at risk of suicide;*

- *Increased investment is needed in supported accommodation for those people transitioning from health services back into the community;*

- *Assistance for medical practitioners in identifying available supported accommodation services for their patients who are at risk of suicide needs to be provided.*

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