No Suicidal Person Should be Left Alone

Lifeline Australia Submission

Senate Community Affairs References Committee Inquiry into Suicide in Australia

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Lifeline AUSTRALIA

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ACKNOWLEDGEMENT

Lifeline pays its respect to those who have tragically died by suicide and in whose memory we now strive to make improvements in suicide prevention in Australia.

Lifeline acknowledges the struggle that many people have with suicide and seeks to listen to and understand the feelings of suicidality within those individuals who attempt to end their lives.

Lifeline recognises the courage of those who live with the intense grief and loss surrounding bereavement by suicide.

To all of you whose stories have been contributed and whose lives and pain has been recorded through this submission, we offer our sincere gratitude and hope that a better future can be made.

1. Executive Summary

Lifeline is the leading service provider in suicide prevention in Australia. Since our inception in 1963, we have provided accessible support to suicidal people and worked to prevent suicide.

More than 91% of all Australians identify the name Lifeline with suicide prevention and the provision of support services.

Our submission is informed by this historical commitment and current experience in working with suicide, especially on our national helpline, 13 11 14. It is also poignantly illustrated by stories submitted to Lifeline's website which profile the human dimensions of suicide in ways that summon us all to a better response. And it is supported by evidence assembled by our research team which draws on their experience within Lifeline, involvement in Commonwealth suicide prevention advisory groups since 1995 and their associations with international colleagues and developments.

Our national helpline 13 11 14 answers more than 450,000 calls a year. Every day of the year, we listen to suicidal people. When appropriate, Lifeline seeks emergency interventions to prevent a person taking their life. Lifeline provides training for people from all backgrounds in the identification of suicidality in others and the practical steps that can be taken to support another person and prevent a death by suicide. We provide bereavement support for those impacted by suicide. More than 91% of all Australians identify the name Lifeline with suicide prevention and the provision of support services.

The Senate Inquiry into Suicide in Australia is welcomed as an opportunity to review the current situation and identify steps for improvement. Lifeline believes more can be done on this major social and health issue in Australia:

- Suicide is the leading cause of death in Australia for all adults under the age of 34. More people die by suicide than by road deaths each year. For men, suicide remains the leading cause of death to the age of 44.
- Lifeline estimates the financial cost of suicide in Australia at $17.5 billion a year – and this does not take into account the financial impacts on those bereaved by suicide and the losses experienced by families and communities.
- Lifeline believes that deaths by suicide are mostly preventable. This belief is supported by evidence provided in the body of Lifeline's submission and held by a majority of Australians. Newspoll research that Lifeline commissioned recently shows that a clear majority of the population (64%) believe that deaths by suicide are preventable.

Yet, there appears to be insufficient focus, organisation and resources for suicide prevention in Australia. Spending by governments on suicide prevention is much lower than for other major social/health areas where prevention can make a difference such as road traffic deaths, domestic violence and cancer.

There is not a single national suicide prevention strategy that is agreed to by all three levels of government in Australia. Accordingly, the efforts by governments on suicide prevention are not strategically aligned, are not intentionally coordinated and are not implemented in way commensurate with the role and responsibilities of each tier of government. This results in less effective outcomes at best and blame shifting at worst.

Lifeline believes that with adequate attention, suicide deaths in Australia can be reduced. We believe reforms to the policy, institutional and research environments on suicide prevention need to be made and participated in the development of a 'sector' submission lodged to the Inquiry.

As a service provider, we deal directly and personally with people and their suicidality. Lifeline is putting forward recommendations that apply to service provision as a non government organisation with a mission to prevent suicide:

1. Formal recognition of and funding for the Lifeline 24 hour helpline 13 11 14 as an essential national service for its role in suicide prevention. This includes mandating that callers to this service pay no call cost. Lifeline also seeks funding for enhancements to 13 11 14, and suggests that hospitals, health and emergency services develop protocols for greater collaboration with this national helpline;
2. Significantly greater investment in training in suicide awareness in the community and suicide intervention skills for professional 'gatekeepers' such as community/social workers, mental health workers and front-line services staff using high quality, internationally respected, programs such as LivingWorks so that far more people are equipped to recognise and respond to another's suicidality.
3. Maintain strategies and programs for high risk groups on suicide, but match these strategies with a commitment to population-based suicide prevention, accompanied by early intervention and follow-up with high risk individuals. Foster locally responsive actions for each region in Australia. This will involve funding for innovative service development, sharing best practice on suicide prevention, and service planning based on accurate data on suicide deaths and attempt levels at a regional and state level.

These three themes are present throughout the specific recommendations that Lifeline is putting to the Inquiry in this submission. They represent a fuller utilisation of Lifeline's unique services and programs within the context of a broad range of strategic initiatives engaging communities, service providers, researchers and governments.

To implement reform and improvement in suicide prevention, Lifeline believes several fundamental shifts need to occur:

- Creation of a national organisation for suicide prevention not attached to any particular government department, able to deal with the cross portfolio

complexity of public policy and social/health factors involved in reducing deaths by suicide.

- Substantial increase – in the order of 10 times current levels - in the total funding for suicide prevention by the Governments of Australia, possibly through a COAG or similar agreement, so that the three tiers of government are providing commensurate resources to their populations and to their roles in suicide prevention.
- Improved accuracy, timeliness and availability of data on suicide deaths and attempted suicide to inform social planning and service needs analysis. This will provide a more strategically tailored service response and a more effective basis for outcomes analysis.

Finally, Lifeline believes in the intrinsic value of non government organisations in achieving results in suicide prevention in Australia. Much of the service response presently is funded and delivered through government or through professions funded by government.

The value of the non government organisation lies in an ability to place respect for the person, compassion, and a flexible response at the centre of all that is done. Non government organisations' core purpose is the pursuit of personal and social outcomes – unfettered by profit or political considerations. Lifeline has through its experience seen what difference a non government organisation can make to individuals impacted by suicide.

At times when other services are unavailable, Lifeline is there for the community. An example of this occurred one Christmas period. The Lifeline manager recalls what happened;

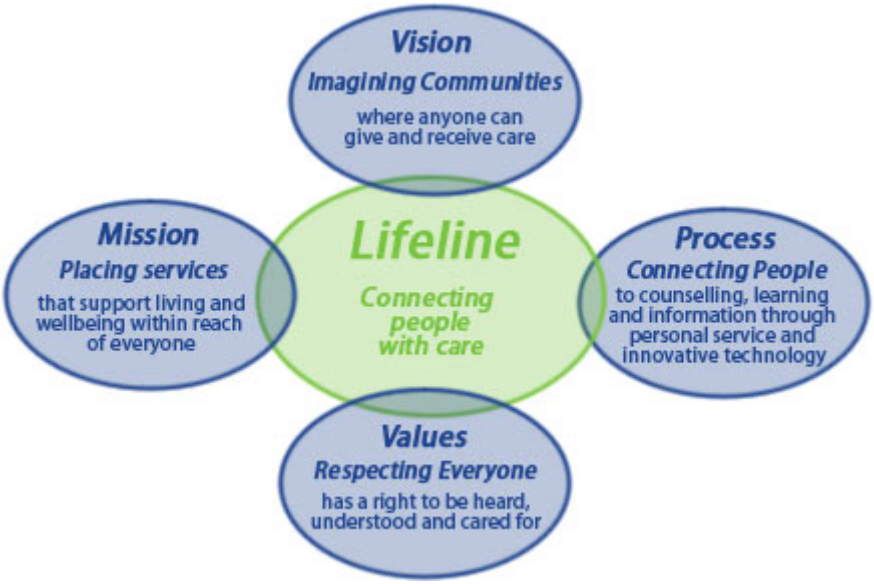
> *"...an urgent call was made [to Lifeline] by the Police following the suicide of a young family man two days before Christmas – we were their last resort as all agencies and charities had closed for the Christmas break. His 12 year old daughter found him in the shed. During that day and over the next few days and weeks Lifeline organised other accommodation, food etc, removal of personal items from the house as none of the family were able to go back into the house. Referral was made to assist the family in paying for the husbands/fathers funeral. Ongoing face to face counselling was provided to the young daughter as she did not want to go to another counsellor and the family was provided with additional support."*
>
> *- Lifeline Manager*

A major change in Australia's approach to suicide prevention should see resources and assistance flowing to non government organisations. In return, non government organisations such as Lifeline can mobilise support from individuals, families and communities to achieve greater outcomes and ultimately less lives lost to suicide. A closer partnership between government, the private sector and non government organisations is needed for suicide prevention in Australia.

2. Lifeline – Leading Provider of Suicide Prevention Services

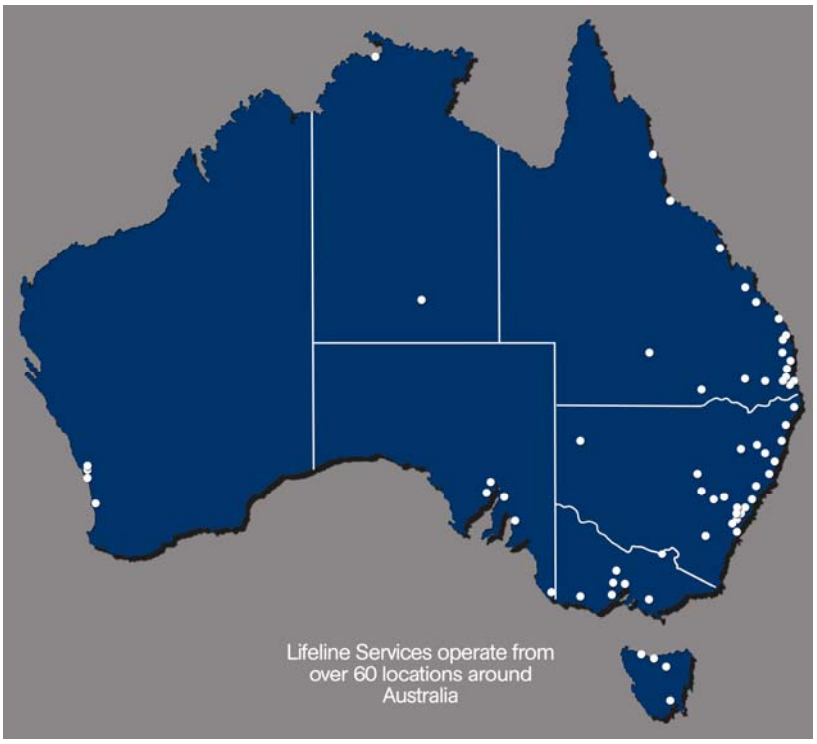
Lifeline was founded as a response to suicide. In 1963 the late Reverend Dr Sir Alan Walker received a call from a distressed man, who three days later took his own life. Determined not to let loneliness, isolation or anxiety be the cause of other deaths, Sir Alan launched a telephone helpline, which operated out of the Methodist Central Mission in Sydney. This service became known as Lifeline.

The vision of Lifeline's founder was to place a 'mantle of care' across Australia so that no individual, wherever they lived, whatever the situation, would be alone in a time of crisis. This vision continues today stated as "placing services that support living and well being within the reach of everyone."



On average over 450,000 calls to the Lifeline 13 11 14 helpline are answered each year by trained volunteers from communities in every State and Territory.

Lifeline has expanded to include local programs in suicide prevention and intensive support services for suicidal persons. Lifeline seeks to transfer skills through the provision of training in suicide awareness and immediate support for suicidal persons. Lifeline also provides services that seek to prevent the onset of crisis in individuals and families, and to promote positive mental health and well being. This includes family relationship services, domestic violence, parenting, drug/alcohol and men's services. Financial counselling and gambling counselling are also delivered by Lifeline. At times of disaster such as flood or fire, Lifeline is actively involved in community recovery.



As a national organisation, Lifeline delivers services from more than 60 locations in Australia, in every state/territory and in many regional/rural areas. This distributed service network means that Lifeline connects tangibly in communities throughout Australia.

Lifeline specialises in flexible, accessible and innovative approaches to service provision. Service delivery is by phone, in person, video conferencing and on line.

Lifeline is part of an international network through its membership of the Emotional Support Alliance.

3. Lifeline's Recommendations to the Senate Inquiry

Lifeline welcomes the Government's decision to establish a Senate Inquiry into Suicide in Australia. We view this as a unique national opportunity to increase understanding of the personal, social and financial costs of suicide, and its impact on people and communities throughout the country. More importantly, the Inquiry can potentially lead to a significantly enhanced, well co-ordinated commitment to suicide prevention in every community, at all levels of government.

The presence of the Inquiry itself signals hope for all those at risk or affected by suicide and those who care for them. Lifeline believes it is the joint responsibility of all involved, to ensure that the process and outcomes of this Inquiry deliver a positive new direction for improved suicide prevention services and support in Australia

The following recommendations summarise the actions Lifeline believes need to be taken to reduce the number of deaths by suicide in Australia, and to provide a more effective suicide prevention strategy.

Senate Inquiry Terms of Reference	Recommendations
(a) Personal, social and financial cost	**1. Provide suicide prevention with comparable national policy focus and resources to other major social and health policy areas such as domestic violence, child protection and motor vehicle accidents.** The cost and impact of suicide warrants this level of priority attention and resources. **2. Ensure that suicide prevention planning, development and resources are informed by a broad understanding of the personal, social and financial cost of suicide.** Key cost and impact indices include: • The personal support needs of those affected; • Social impact research; • Multifactorial modelling on cost analysis.
(b) Accuracy of suicide reporting	**3. Address practical, social and attitudinal barriers as well as procedural issues in improving the accuracy of suicide reporting in Australia.** This could include: • Providing training to front-line workers (such as police and coroners) on how stigma and denial can impair

	acknowledgement of suicide deaths; • Promoting openness, acknowledgement and understanding of suicide in the community; • Reviewing insurance, superannuation and other financial benefit scheme practices to remove different provisions where the death is by suicide. **4. Resource coroners to provide surveillance and timely communication to governments and to service providers on suicide deaths to inform prevention activity.** This could include: • Early notification about potential emergence of suicide clusters in communities; • Preliminary advice about elevated suicide risk associated with community trends (such as unemployment) or community crises. • Improved public education on the prevalence of suicide, prevention activities and available help. **5. Develop procedures to document and report to governments and to service providers on the incidence of non-fatal suicidal behaviour (ie: attempts and self harm) as a guide to prevention initiatives.** At the community level, this information provides an indicator of distress requiring increased supports, resources and suicide prevention activities. At the individual level, it provides foundations for targeted responses to persons with a significantly elevated risk of suicide (See Terms of Reference item f).
(c) Appropriate role and service effectiveness of agencies	**6. Mandate and fund the Lifeline 13 11 14 nationwide 24 hour helpline as an essential suicide intervention service.** This would enable callers to contact the service without incurring any call costs. **7. Fund extension and service development for 13 11 14 in areas in which its effectiveness in suicide prevention can be enhanced:** This could include: • Funded field trials of a '1-800 Suicide' number (owned by Lifeline) to create a dual access gateway to the Lifeline helpline – recognising some callers may readily self identify as seeking a suicide service;

	• A funded extension to 13 11 14 for a follow-up service to provide suicidal callers with enabling support and safe-transition to additional services and supports following the initial crisis contact. **8. Implement measures such as MOUs and protocols on role clarity and collaboration between non government suicide service providers and agencies such as police, hospitals, emergency and mental health services in responding appropriately to people at risk of suicide.** **9. Promote collaborative community solutions for suicide prevention based on tools such as the LivingWorks, Working Together program.** **10. Develop and implement crisis response capabilities for responding to emerging suicide clusters or areas where elevated suicide potential is present following community disasters.** This could include: • Developing guidelines accessible to local community service providers as needed, modelled on local and international examples; • Equipping and mobilise 'crisis teams' to work collaboratively with local communities where increased suicide risk is evident; • Providing support for communities dealing with the aftermath of suicide, working within Australian national bereavement support guidelines. **11. Review the provisions and / or interpretations of privacy laws or guidelines as they affect communications between service providers and those caring for persons at risk of suicide.** **12. Ensure there is debriefing and supervision for frontline workers (especially emergency response personnel) exposed to a suicide related incidents.**
(d) Effectiveness of public awareness programs regarding information dissemination, promoting help-seeking and public	**13. Commit the authority and resources of the Australian Government to a dedicated community awareness/ social marketing campaign on suicide prevention.** This would adopt a whole of community approach and should address issues such as: • Stigma – encouraging safe, open discussion of suicide;

discussion of suicide	• Information about suicide warning signs • Options and carriers to seeking and providing help The LivingWorks program *SuicideTALK* is recommended as an example of a community development tool on how communities can strengthen life-promotion and suicide prevention activities. **14. Whenever there is a suicide attempt, ensure that the family members and carers receive awareness training to respond appropriately and facilitate safety.** The LivingWorks' safeTALK and Applied Intervention Skills Training (ASIST) are recommended as examples of relevant awareness training programs.(See Terms of Reference item e);
(e) Efficacy of suicide prevention training and support for frontline health community workers	**15. Commission and fund systematic gatekeeper training for community leaders and front line workers to be suicide intervention first responders.** This could include: • Provide suicide intervention training in every workplace; • Provide role appropriate suicide intervention training for emergency services and mental health personnel at every location of service; • Provide appropriate suicide intervention training for every secondary and tertiary educational institution. Lifeline has the capability to provide national leadership to suicide intervention training in Australia through its network of LivingWorks *safeTALK* and *ASIST* trainers present in all states and territories, including rural and remote regions. **16. Ensure suicide screening and risk assessment training as a basic professional development requirement for all workers in health and human services.** This would include: • Identification of role-appropriate levels of training; • Focus on workers such as physicians, psychologists, family relationship counsellors, social workers and nurses, financial counsellors, drug and alcohol workers; • Establishment of a core unit covering suicide for all health related undergraduate and postgraduate courses (nursing, medicine, psychology, social work) in every Australian tertiary institution. • Establish and recognise suicide prevention training as a

	priority professional development activity for health, human services and education personnel.
(f) Role of programs targeted to high risk groups	**17. Ensure that prevention activities targeting high risk groups are embedded in a broader population strategy and accompanied by early intervention and follow-up with high risk individuals;** **18. Ensure that appropriate follow-up care is provided for all persons who have engaged in prior suicidal behaviour;** **19. Introduce specific care and support services to accompany an appropriate discharge and treatment plan for suicidal persons;** **20. Design, trial and develop service models for residential care for suicidal persons in every capital city, including provision for their carers similar to post recovery units offered in other areas of medical care;** **21. Create service options that address contextual factors materially affecting suicide risk (such as housing, employment, material aid);** **22. Develop and resource post-release oriented suicide prevention programs in corrective institutions in every state and territory in Australia;** **23. Develop and implement a suicide prevention and bereavement support strategy for Indigenous persons as a national priority.** Key implementation issues include: • Ensuring that responses are culturally appropriate and recognise diversity among indigenous people as well as common needs; • Engaging indigenous people in the preparation, delivery and evaluation of services; • Offering both community-based and individual approaches; • Integrating suicide prevention strategies with other initiatives among indigenous people that address areas such as health, housing, education and employment; • Taking into account the impact of the National Strategic Framework for Aboriginal and Torres Strait Islander people's mental health, social and emotional wellbeing. **24. Establish and implement a national strategy for removing or reducing access to the means of suicide.**

	This strategy could address such issues as: • Targeting hot spots • Bridge and railway barriers • Safe use of medications • Reducing abuse of alcohol and other drugs • Considering whether any further measures with gun control and motor vehicle safety are needed**.**
(g) Adequacy of current research into suicide and manner in which findings are disseminated to practitioners and incorporated in government policy	**25. Develop and implement a national research and evaluation agenda to review and improve the effectiveness of suicide prevention and postvention activities.** Aims are to: • Build the evidence base on effective or promising strategies; • Identify approaches associated with safe outcomes likely to feature prominently in future development; • Ensure that results are widely disseminated to consumers, providers, planners and funders. Key elements include the following: • Define areas of national interest, guided by Australian and international work already done on establishing suicide prevention research priorities; • Align the research and evaluation agenda to national priorities in suicide prevention and bereavement support; • Complement scientific research on clinical interventions with social research on the causes and prevention of suicide; • Ensure consumer involvement in developing and implementing research and evaluation.
(h) The effectiveness of the NSPS in achieving its aims, objectives and barriers to progress	**26. Establish and promote an Australian best practice registry to guide service standards and enable evidence based approaches to suicide prevention.** This publicly accessible Registry would: • Operate as a clearing house for evaluation and research; • Collect and disseminate best practice standards, guidelines and resources relating to evaluation and service provision information and advice;

	• Guide developers of programs and services; • Inform consumer choices about programs and services. **27. Ensure that the National Suicide Prevention Strategy is endorsed, funded and implemented by all levels of government (Federal, State and Local).** The aim is to vertically integrate and engage all levels of government in suicide prevention activities commensurate with their roles. **28. Broaden support for the National Suicide Prevention Strategy by actively engaging commitment, financial resources and involvement from the corporate and community sectors to complement government involvement.** The aim is to encourage broad, collaborative community, corporate and government engagement with suicide prevention in Australia. **29. Create a national body to develop, co-ordinate, implement and monitor the National Suicide Prevention Strategy** **30. Engage consumers more actively in the development, delivery and evaluation of suicide prevention services.** This would specifically include: • Persons bereaved by suicide • Suicide attempt survivors • Those caring for persons at risk. **31. Develop mechanisms to enable pilot project activity shown to have efficacy to be disseminated widely and provided with ongoing funding.**

Response to Terms of Reference

4. The personal, social and financial costs of suicide in Australia (ToR (a))

"His suicide has been the most profound single event in my life that I have had to deal with, and continue to deal with. 4 yrs later, there are no answers for me and the guilt & sadness are overwhelming."

- Personal story submitted to Lifeline

4.1 Personal Costs of Suicide

Lifeline responds to the personal impact of suicide every day as the leading service provider in Australia of suicide prevention services.

When the Senate Inquiry into Suicide in Australia was announced, Lifeline invited personal stories from the Australian public, from people who live with suicidal thoughts, have attempted suicide, are bereaved by a loved one's suicide, or support someone in any of these situations.

This was seen as an opportunity for those who have experience with suicide to have their voice heard, and to help all Australians recognise the far reaching impact of suicide on the lives of those touched by it.

Lifeline received 129 personal stories in a 5 week period. All personal stories may be found in **Attachment A**. We ask that Attachment A be kept **CONFIDENTIAL** to protect the respondents, and any third parties, from having their stories made public.

The majority of these stories were from people who had experienced the suicide of someone close to them – often within their families. In some cases, the stories reflect experience with multiple suicides, sometimes within the same family. While reflecting the intense pain, guilt, soul searching and aloneness associated with suicide loss, these stories also provide unique, poignant insights into the painful inner turmoil of the loved ones who suicided.

There are abundant markers and signposts in these stories highlighting ways in which individuals, communities and governments could do much more to prevent future suicides.

Heeding these voices is a way of honouring those people who have died by suicide and those impacted by their deaths. It may also ensure their legacy can contribute to the prevention of future suicides for many who are at risk, yet still alive today.

From all personal stories, it is clear that the impact of suicide is far greater than can be measured using statistical means. These stories demonstrate the human element of suicide, and its effects on the people who experience so much pain that they purely want it to end, and the consequential pain for those loved ones left behind. Emotions of guilt, sadness, loneliness and hopelessness are expressed not just by those who are experiencing suicidal thoughts, but also from those people who have lost someone to suicide.

4.2 Suicide Can be Prevented

A resounding theme in many stories from the bereaved was that they felt the suicide of a loved one could have been prevented. This is a view long-held by Lifeline. Some state that if their own awareness and knowledge around suicide was greater, they could have perhaps recognised the signs and tried to help. One person whose son and husband suicided within a decade had subsequently attended a two day suicide prevention training course:

> *"I am astounded at how easy it would be for all of us to recognise early warning signs of suicide" she wrote. "If only I had been given this knowledge nine years ago, how different my life would have been."*
>
> *- Personal story submitted to Lifeline*

In the majority of stories people express the view that suicide awareness and prevention training is required on a national scale; to provide the knowledge in identifying suicide cues being exhibited, and to develop the skills to provide support for a suicidal person.

A person who is suicidal may not be in the best position to be seeking the help, a number of story writers acknowledged. As a community, Australians need to ensure that when someone does reach out for help, they are linked with someone who is equipped to provide them with appropriate support. In order to do this, the Australian community needs a basic knowledge of what signs of suicidality to look out for, how to have safe conversations around suicide, and how to access appropriate help.

A haunting revelation made by some people who had attempted suicide was the common feeling that when they made a suicide attempt, they never really wanted to end their life, but rather take away the emotional pain that they were experiencing in that moment.

"When the attempts at suicide were made, they were never really made to kill myself but just as a cry for help to take away the emotional pain. I describe my attempts at suicide as being like "tunnel vision" and not being able to see any way out except death. I also describe them as an attempt to remove the emotional pain from my life or numb some for a little while anyway."

- Personal story submitted to Lifeline

Imagine if every person who was going through such emotional turmoil had someone who could sit down and talk with them about their options for working through their problems, and decide together what could be done to ease their emotional pain, without having to end their life.

4.3 The Shortage or Deficiency of Professional Care for Suicide

Stories from the people bereaved by suicide often expressed that a number of health agencies "let them down". All too frequently, these stories recall how their loved one was turned away from care, not provided with appropriate care or follow-up care, or that friends or family members were not informed or involved in the care planning of the suicidal loved one.

A clear sense of frustration and guilt ensues for these families and carers when they communicate that they were in the best position to recognise high risk behaviour and offer support, but they had not been informed that their loved one was feeling suicidal, or provided with the tools to know what to do. When a professional adopts a privacy policy that excludes contact with other members of a patient's family, important information which could be vital to the treatment of the patient is lost.

Service failure and a lack of continuity of care were overwhelmingly expressed by the majority of story writers.

A sense that very few people are comfortable dealing with suicide, including the professionals which suicidal people may reach out to for help, is conveyed in these stories.

Sufficient resources and education for these front line workers is required. This is expressed by a great number of people who have had a personal experience with hospital staff, general practitioners, counsellors, psychologists, psychiatrists, CAT teams, police, and ambulance staff.

Sadly, it was expressed that those who do reach out for help to professionals when feeling suicidal often do not receive it, perceivably through the ignorance or fear of the professional, or because they become disheartened by previous disappointments with professional care, the prospect of associated costs, or waiting times which are experienced.

Better access to care, and a range of help being made available (particularly in rural and remote communities) was expressed throughout the majority of stories. What works for one individual will not necessarily be effective for another. There is no 'one size fits all approach', and as such, a number of options for care need to be made available to suicidal people.

A more holistic approach to care was conveyed as being required by a number of people. Relationship issues, financial strain, career pressures, abuse, and alcohol and drug dependency were just some of the other contributing factors discussed by story writers. Services dealing with these issues, which recognise and acknowledge suicidal ideation as a possibility in these situations, need to be made available.

4.4 Rural and Remote Challenges

People who wrote about their experience with suicide and living in rural and remote areas expressed that often help is not available in the local town, forcing people to either travel to major centres, or wait for a scheduled time when relevant professionals travel to a town from a major centre. In some cases, this delay may be too late. Frustration was also expressed about long waiting lists, and often having no alternatives for the suicidal person's care.

4.5 The Misunderstanding and Stigma Associated with Suicide

Experience of a fear of the unknown around suicide was reflected in many stories, and a resounding recommendation from those with suicide experience was that suicide awareness campaigns, and education around suicide needs to be provided to the Australian community; starting with our youth.

Stories reflected that we have a duty of care to make it easier for future generations to discuss and address suicide, providing them with the tools to recognise, acknowledge, and prevent suicide.

The reluctance to ask the question "are you feeling suicidal?" was emphasised in a number of stories. Some stories pointed out that those in health professions have also exhibited a stigma or dismissiveness towards suicidal people who reach out to them, lacking compassion towards the suicidal person.

Many contributors told how family suicides were kept secret or covered up for years; sometimes for decades out of shame, ignorance or simply not being able to find ways to talk about it. Some of the stories from bereaved writers also reflect on their own family's stigma around suicide, and their attempts to label a loved one's death as 'a heart attack' or similar, to prevent their community from knowing the real cause of death, and making judgements around that.

Blame and guilt were a common theme in most stories of people bereaved by suicide. This reflects widespread ignorance about the complex causes of suicide. The anger experienced following a loved one's death by suicide was also reflected upon. Some people reported being unable to even mention the loved one's name around family who

were angry at the person for taking their life. In this sense, these people expressed not only losing the loved one, but their ability to speak about them with the people who shared their life.

4.6 Mental Illness and Suicide

Many of the personal stories discuss a link with diagnosed mental illness. In many other cases, it is clear that disabling mental health conditions were present but were unrecognised at the time. This was often recognised in retrospect by the bereaved. The experiences of many individuals living with such illnesses was clearly apparent in many stories. Depression, including bi-polar disorder and anxiety disorders commonly featured in these stories and were sometimes complicated by diagnosed personality disorders.

4.7 Alcohol and Behavioural Factors

Problem drinking, often over an extended period, was clearly associated with many of the suicide deaths in these stories. It featured as a contributing factor in a downward spiral of deteriorating relationships, employment difficulties and general despair which exacerbated loneliness and alienated key supports.

What is remarkable is the resilience and sustained support offered by many significant others seeking to support people whose lives were affected by alcohol misuse. What is tragic is how little support many of these people received from services.

Other behavioural issues associated with these suicides include a history of abuse, problem gambling and deficits in social skills. A history of loss, often multiple losses, was also present in most of these stories.

4.8 Family Interventions After a Suicide

A striking feature of these stories was how often those left behind had to cope with minimal informal or professional support.

In some cases, where multiple suicides occurred in a family, one wonders whether later deaths could have been prevented had a more comprehensive response been available after the first suicide. Suicides often identify families in need of more support than they are currently receiving.

The stories provide several clues to what would have helped and where future prevention and bereavement support initiatives need to focus their efforts.

First, ignorance, stigma, fear and uncertainly about what to say or do clearly remain barriers to the provision of support by community members when a suicide occurs. Much needs to be done to improve community awareness about suicide and dispelling stigma which creates a wall of silence that isolates families at a time of deep need.

Second, a more proactive and better co-ordinated service response after suicide were called for. Many of these stories consistently talk about the lack of service supports, not only in the weeks following the suicide but over time.

Thirdly, most recognised that formal service responses can only achieve so much and that the promotion and demonstration of common values are needed such as care, support, compassion and understanding.

4.9 Support for Those Who Attempt Suicide and Their Loved Ones

In some instances it is those who attempt suicide and survive who have to rebuild their lives. Many suicide attempt survivors do not seek help or reveal their suicide attempt to loved one's, and this makes it particularly difficult to provide support to this group of people affected by suicide.

Sadly, even when suicide attempt survivors, or their families, seek support, it is often not perceived to be there. Some story writers recalled that upon approaching family members or friends and having the courage to express that they were feeling suicidal, they were rejected by these trusted people, presumably due to fear or disbelief. Many of those who attempted suicide also expressed that they had done so on a number of occasions, and continue to struggle with suicidal thoughts frequently. For these people, being able to maintain any sense of "normalcy" in their lives is particularly difficult, especially in regards to sustaining employment and the vital relationships in their lives.

There is also a clear need for follow up services, and support networks, for the family, friends, and carers of people who attempt suicide. Lifeline is aware of the differences in context that these loved one's face in comparison to those loved one's bereaved by suicide, and it was expressed by some story writers that a different type of support would have been useful after a family member had attempted suicide.

As stated by a mother whose son had attempted suicide;

> *"Unfortunately there are [no support groups] for families of attempted suicide victims. There seems to be plenty of support for people bereaved by suicide, but I didn't think that was the right forum to share my feelings. I spent a long time trying to access support for myself in my situation, but I found nothing was available. It would have been such a huge help."*
>
> *- Personal story submitted to Lifeline*

To try and place those bereaved by suicide with those who have had someone close to them attempt suicide in the same support groups will not cater to their unique circumstances. Whilst bereaved loved one's and those who have someone who has attempted suicide may share similar emotions of sadness, confusion, guilt and shock, those loved one's of someone who has attempted suicide have a unique opportunity to support that person because they are still alive. In line with this, they may also have an added level of anxiety around the future of that loved one, and that they may attempt suicide again.

These people may require a different kind of support than those bereaved by suicide, and may require education about supporting that loved one during this fragile and critical time.

4.10 Lives Changed Forever

The reality is, that for many of those who are bereaved by suicide, they will be haunted by losing a loved one to suicide every day for the rest of their lives, and all story writers were unified when they expressed that losing a loved one in this way should never happen.

In many instances, the bereaved by suicide left their employment when the suicide occurred, and reported feeling as though they could no longer live in the home they shared with the loved one, or even the same city or town.

Some reported that close relationships with their own support networks also suffered, often due to a friend not knowing what to say, and avoiding the bereaved person. Having to grieve the often sudden and unexpected loss of their loved one, paired with having to rebuild almost every aspect of their lives, meant that many who were bereaved by a family member's suicide expressed that they began feeling suicidal themselves with the weight of the burden.

Encouragingly, there were a number of stories where those bereaved by suicide, and those who had attempted suicide in the past, are using their experience for the good of the community today, and trying to raise awareness around suicide prevention within their own communities. Many report going on to become counsellors, or playing key roles in the delivery of bereavement support groups themselves.

Suicide is the leading cause of death in Australia for adults under the age of 34

The enormity of pain and confusion experienced by someone touched by suicide is obvious from reading all 129 stories. This summary can only touch on common themes being presented. By no means can it capture the important finer details of the reality that these people face every day, as they have done so eloquently in each of their narratives. To capture a true sense of the human experience of suicide, all stories should be read.

Those who responded clearly wanted to tell their stories and have them heard. Having been entrusted with these stories, reading them is a way of honouring their experiences and learning from them as we seek to prevent future suicide deaths.

4.11 Social Cost

By any measure, suicide is having a profound impact on schools, groups and communities in Australian society.

- Suicide is the leading cause of death in Australia for adults under the age of 34 years.
- For men, suicide is the leading cause of death for those under the age of 44 years.

The national mental health and well being survey provides the following data on the prevalence of suicide, suicide attempts and suicidal ideation in Australian society:

Prevalence & population estimate of lifetime & 12-month suicidality (Australians 16-85 y.o., n=8,800) (*The Mental Health of Australians, 2008)*

	Lifetime prevalence %	Population estimate	12-month prevalence %	Population estimate	Days out of role
Suicidal Ideation	13.3	2.1 million	2.3	370,000	
Suicide plans	4.0	Over 600,000	0.6	91,000	8.2 days per month
Suicide attempts	3.3	Over 5000,000	0.4	65,000	8.5 days per month
Any suicidality	13.3		2.4	Over 380,000	6.7 days per month

Note: Any suicidality is lower than the sum as people may have reported more than one type of suicidality in the 12 months.

* Please note 'Days out of role' refers to an inability to go about normal daily activity in life roles such as being an employee, volunteer, parent, carer, sibling etc.

These figures suggest that suicide is a major social issue for Australians.

The social impacts of suicide are complex and require a deeper examination of the qualitative factors. Suicide continues to be stigmatized and consequently isolates people by its silence. It has a deep psychological/spiritual impact due to its direct contradiction to our innate desire to live. Suicide fractures relationships and gives rise to complex feelings including: shame, anger, shock, blame, denial, trust, loneliness, guilt, sadness, and confusion.

As well as costs to the individual it is important to contextualise suicidal behaviour and appreciate the ripple affect caused in the lives of friends, family members, colleagues, and acquaintances. The number of people immediately affected by any one suicide has

conservatively and historically been estimated as up to 6[1]. This measure probably underestimates the number of people grieving each suicide death, the ramifications of which are likely to extend more broadly. Potentially, three to four generations can be affected. Relatives, friends and the wider community are also impacted. It has been stated that there are as many as 28 relationships impacted by one suicide[2]. People will be impacted in many and various ways by a single suicide.

The research has simply not been done to articulate the actual number of people impacted, nor the breadth, depth and length of this impact. Nor has the research addressed the impact of multiple suicides which occur in one family, community or one geographic region.

The impact for society is a compound picture with individuals disconnected from their community and in the case of suicide clusters, whole communities reeling in disbelief and often perceived impotence to stop the trend. The complete impact of a suicide, its destabilising and unsettling influence in a community (especially in a small town, a workplace, or a school) has never been mapped.

4.12 Lifeline's Experience - Rural and Remote Communities

Lifeline's experience in rural and remote communities is that an individual suicide in these smaller communities can have a particularly strong impact, with somewhat of a ripple effect.

This experience seems to be common regardless of which rural area the suicide occurs. It is not unusual that the person who dies by suicide and their family are known to a significant number of people living in close proximity to each other. Lifeline has recognised that the response to someone's death by suicide in a rural community is often a generalised community one.

Lifeline's experience has shown that in farming areas, particularly in remote regions, the death of another farmer by suicide is particularly confronting. The culture of a farming community is still that the men in particular do not express their feelings, and tend to act out their pain instead. These communities tend to pull together to support each other, but in times of drought and economic hardship, the death by suicide of someone known and who had lived in the same circumstances can be hard for other farmers to bear.

4.13 Lifeline's Experience - Indigenous Communities

In Queensland, the Northern Territory, Western Australia and New South Wales, Lifeline has had involvement with Indigenous communities and their experiences of suicide. Indigenous communities are often in a constant state of grief and loss, through deaths, separation, addictions, disease and children being taken into care.

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[1] Clark S. & Goldney R. (2000). The impact of suicide on relatives and friends. In: K. Hawton & K. van Heeringen (Eds.), *The International Handbook of Suicide and Attempted Suicide*, pp. 467–484. John Wiley and Sons, Chichester; Maple, M., Edwards, H., Plummer, D., Minichiello, V. (2009). Silenced voices: hearing the stories of parents bereaved through the suicide death of a young adult child. *Health and Social Care in the Community. In press.*

[2] Campbell F. (1997) Changing the legacy of suicide. *Suicide and Life-Threatening Behavior 27 (4),* 329–338.

Vulnerability to suicide is common in Indigenous communities that are in a constant state of stress. In this environment, it is difficult to locate people in families or communities who are available, and free enough of their own stresses, to give their full attention to a suicidal person.

Lifeline has also found that when young Indigenous people die by suicide, copy cat suicides can follow. It has also been Lifeline's experience that a number of hanging deaths by Indigenous people are reported by police to be impulsive acts resulting in accidental deaths. Lifeline has developed and provided some culturally appropriate training to Indigenous Communities.

4.14 Lifeline's Experience – Schools and Suicide

Lifeline has experience with youth suicide. In some areas, multiple youth suicides have occurred in local schools. In one community alone, Lifeline noted that six suicides occurred in the one school in a relatively short period of time.

The impact of deaths by suicide in a school community can be highly intense, and without an appropriate response can create an environment where other deaths become likely.

These circumstances have resulted in Lifeline increasing its involvement with students at schools in some communities, supporting and enabling students, parents and teachers around how to talk about suicide in an open but safe way.

4.15 Financial Cost

The financial cost of suicide has never been fully counted in Australia. Efforts to estimate the financial cost of suicide face debates about the statistical value of a life:

> *"The valuation of life is generally an emotive issue fraught with philosophical and conceptual problems. Consequently, it is an issue riddled with controversy and debate. It is also associated with seeming irrationalities. For example, society will usually go to great lengths to save identified lives such as sailors stranded in mid-ocean or a child in need of expensive surgery. However, when the lives to be saved are anonymous, as for example in the case of funding research into cures for disease that would save lives in the future, public response may not be quite as generous. This apparent irrationality may be due to the greater sense of responsibility and claims of conscience associate with identified lives as opposed to anonymous lives."*[3]

There continues to be robust debate amongst economic theorists as to how to most accurately estimate the Value of a Statistical Life (VoSL). In recent years, there has been heightened interest in the development of health outcome measures that combine

[3] Motha, J. (1990). The valuation of human life: approaches and Issues (with special reference *to accident costing*, Paper presented to the 19th Conference of Economists Sydney 24- 27 September, Bureau of Transport and Communications Economics.

morbidity (quality of life) and mortality (quantity of life) in a single measure. Proposed indices include the Quality of Life Years, QALYs and Disability –adjusted Life Years, DALYs. Discounting is commonly employed to reflect society's preference for health gains that accrue sooner rather than later in time, and costs that occur later rather than sooner in time. A variety of methods have been used to value life and health or the cost of illness. Examples include human capital (foregone earnings), willingness-to-pay (WTP) estimated through indirect market methods and cost –or-illness.

The most recent piece of research re-evaluating the cost of human lives lost in car accidents was published in June of this year[4]. Professor David Hensher from Sydney University's Institute of Transport & Logistics Studies puts the average cost of a life at $6million, four times the $1.5 million which was previously used to estimate the cost of road accident deaths.

Financial cost also needs to address the difficulties in obtaining reliable data on deaths by suicide in Australia. The most recent ABS data (released March 2009) reporting annual suicide deaths in Australia puts the count at 1,881 (2007). However, the Australian Institute of Health and Welfare Report[5], analysing data from 2004, shows the many inaccuracies and misclassifications in determining the ABS reported data and estimates that the annual number may be 16% higher. Their review of 2004 suicides puts the annual count more likely at 2,458 for 2004, compared to that years' ABS reported total of 2,110.

It is plausible that the total number of deaths by suicide is now greater than this due to the influence of the economic downturn and Global Financial Crisis. If a figure of a 10% increase in deaths is adopted, the total number of deaths in Australia could now be at 2,704 per annum.

If the most recent research available is used to extrapolate the value of a life and the revised estimate of suicide deaths is adopted then:

2,704 suicides x $6m = $16.2 billion

Based on AIHW hospital admission and cost data, then a further $133.3M would be added for cases of self-inflicted harm.

The total financial cost of suicide in Australia is likely to be in the order of $17.5 billion per annum.

[4] Hensher, DA et al. (2009). Estimating the willingness to pay and value of risk reduction for car occupants in the road environment. Transportation Research Part A 43. 692-707.
[5] Australian Institute of Health & Welfare (AIHW): Harrison JE, Pointer S, Elnour AA (2009). A review of suicide statistics in Australia. Injury research & statistics series no. 49. Cat no. INJCAT 121. Adeliade: AIHW.

Recommendation 1: *Provide suicide prevention with comparable national policy focus and resources to other major social health policy areas such as domestic violence, child protection and motor vehicle accidents.*

The cost and impact of suicide warrants this level of priority attention and resources.

Recommendation 2: *Ensure that suicide prevention planning, development and resources are informed by a broad understanding of the personal, social and financial cost of suicide.*

Key cost and impact indices include:

- *The personal support needs of those affected;*
- *Social impact research;*
- *Multifactorial modelling on cost analysis.*

5. The accuracy of suicide reporting in Australia, factors that may impede accurate identification and recording of possible suicides, (and the consequences of any under-reporting on understanding risk factors and providing services to those at risk) (ToR (b))

5.1 Inaccuracy in Suicide Reporting in Australia

The accuracies in the reporting of suicide has been questioned by academics and researchers for some years now[6]. This has been acknowledged by the Australian Bureau of Statistics in their data reporting for the past few years.

The quality of suicide statistics are affected by a number of factors including the number of open coronial cases with insufficient information available for coding at the time of ABS processing. The ABS notes that particular issues experienced in recent years may explain at least part of the observed decline in the number of suicide deaths. Thus extreme caution must be taken when comparing trends in the number of suicides over recent years[7].

Lifeline is pleased that, as a result of this situation, the Commonwealth Department of Health and Ageing has provided funding to Suicide Prevention Australia (SPA) to oversee the National Committee for Standardised Reporting on Suicide (NCSRS). This action is consistent with the National Suicide Prevention Strategy (2007) outcome: "Progress a national standardised recording system relating to deaths through suicide".

[6] De Leo, D. (2007). Suicide mortality data need revision. *MJA; 186* (3), 157-158.
[7] Australian Bureau of Statistics (2009). *TECHNICAL NOTE 1- ABS CODING OF SUICIDE DEATHS* . http://www.abs.gov.au

5.2 Importance of Accurate and Accessible Data on Suicide

Accurate statistics on suicide are crucial to national, state and regional suicide prevention strategies and to the development of service priorities and funding levels.

Suicide and suicidal behaviours are an important public interest and policy issue. The rate of suicidal behaviours is widely used as a progress indicator and informant to service delivery. Data on the means of death and the circumstances surrounding suicidality is essential for proper planning on suicide prevention. It is therefore imperative that reliable statistical information on the prevalence of suicidal behaviour in Australia is made available to community and service providers.

It is also vital that this data be available in a timely and accessible fashion. As a service provider, Lifeline understands the importance of data to inform service operations, service development and to identify service gaps and take responsive action. Better access to accurate information on suicide and suicidal behaviour could enable more effective local responses to communities and regions in Australia – notably in cases where several deaths by suicide occur in a short space of time. The early identification of 'clusters' of suicide in localities or particular social/demographic groups will support more effective suicide prevention responses.

Another factor relating to the under-reporting of suicidal incidents in Australia is that in terms of reporting on rates and numbers of attempted suicide, only about 30% of those who have made a suicide attempt present at Accident and Emergency[8]. Hospital separations would be just one way to endeavour to enumerate suicide attempts in Australia[9], however as many of those who have attempted suicide do not seek help, this would mean a significant underreporting. Again, reliable and timely data on suicide attempts can assist in more responsive services and support and more effective suicide prevention.

5.3 Lifeline's Experience with Suicide Data and Reporting

There are many impediments to accurate reporting of suicides. Social and cultural barriers, especially stigma, need to be addressed alongside technical processes associated with criteria for determining suicides and procedural matters affecting data collection and timing.

Lifeline's experience is that these barriers can be critical factors in the accuracy of data and reporting, and that they reflect attitudes and stigma surrounding suicide that itself is a major barrier to suicide prevention in communities.

[8] De Leo, D., Cerin, E., Spathonis, K., Burgis, S. (2005). Lifetime risk of suicide ideation and attempts in an Australian community: Prevalence, suicidal process and help-seeking behaviour. *Journal of Affective Disorders, 86,* (2-3), *215-224.*
[9] Bradley C & Harrison J (2008). Hospital separations due to injury and poisoning, Australia 2004–05. *Injury Research and Statistics Series Number 47*. (Cat. no. INJCAT 117) Adelaide: AIHW.

Stigma

Lifeline is aware of circumstances where the family members either directly or indirectly seek to influence death certificate statements regarding suicide.

There have also been examples where local funeral directors have discussed with Lifeline that the families of people who have died by suicide have the funeral notice request funds to the “Cancer Foundation or Heart Foundation”, so that the general public thinks that the person died as a result of these causes, and not from suicide.

In some areas, Lifeline knows of families that have buried their loved one’s who died by suicide in another town, so that local people will not know the death was by suicide.

Religious and Cultural Beliefs

Lifeline is aware of an example that illustrates the complexity of how the determination of ‘Cause of Death’ might impact those left behind. This is about a mother whose son suicided by driving his car into a tree. He had previously attempted suicide and had a history of mental illness. There were no brake marks on the road and witnesses state that the car veered off the road and headed towards the tree. For this mother, who holds strong religious convictions and beliefs that if her son suicided she will not see him in heaven, she was relieved that the ‘Cause of death‘ was recorded as single vehicle road accident and not suicide.

Financial and Economic Factors

Lifeline has seen examples of ‘Cause of Death’ being recorded as other than suicide to avoid financial impacts on a family. Some insurance and benefits schemes impose delay of payment provisions where the death is by suicide. In regional and rural areas in particular, this delay can have a catastrophic impact on the economic future of a family, such as where a family farm or business is involved. Accordingly, inaccurate recording of the cause of death can occur through the intention to avoid financial hardship for a family – especially in smaller communities where families know each other and socialise together.

Recommendation 3: *Address practical, social and attitudinal barriers as well as procedural issues in improving the accuracy of suicide reporting in Australia.*

This could include:

- *Providing training to front-line workers (such as police and coroners) on how stigma and denial can impair acknowledgement of suicide deaths;*
- *Promoting openness, acknowledgement and understanding of suicide in the community;*
- *Reviewing insurance, superannuation and other financial benefit scheme practices to remove different provisions where the death is by suicide.*

Recommendation 4: *Resource coroners to provide surveillance and timely communication to governments and to service providers on suicide deaths to inform prevention activity.*

This could include:

- *Early notification about potential emergence of suicide clusters in communities;*
- *Preliminary advice about elevated suicide risk associated with community trends (such as unemployment) or community crises.*
- *Improved public education on the prevalence of suicide, prevention activities and available help.*

Recommendation 5: *Develop procedures to document and report to governments and to service providers on the incidence of non-fatal suicidal behaviour (ie: attempts and self harm) as a guide to prevention initiatives.*

At the community level, this information provides an indicator of distress requiring increased supports, resources and suicide prevention activities.

At the individual level, it provides foundations for targeted responses to persons with a significantly elevated risk of suicide (See Terms of Reference item f).

6. The appropriate role and effectiveness of agencies, such as police, emergency departments, law enforcement and general health services in assisting people at risk of suicide (ToR (c))

"I feel completely let down by the mental health system and the government. We were offered more support after Dad's death than we ever were while he was alive. Something has to be done. My Dad could have been saved. Things should not be this way."

- Personal story submitted to Lifeline

"At the times when he was hospitalised, no-one ever talked to me. And I mean never. I did try once and patient confidentiality was brought up. Well poo to that I say. Look what happened. Confidentiality or a life. I had no guidelines, no advice, no help."

- Personal story submitted to Lifeline

6.1 Lifeline 13 11 14 – An Essential Service in Suicide Prevention

It is a basic human right to receive appropriate services. Lifeline believes that the most important reform required in suicide prevention in Australia is for agencies and general health services to formally recognise, collaborate with and interact more with suicide-specific services such as the Lifeline 13 11 14 helpline, for improved access to support for suicidal people, and for greater continuity of care and follow-up.

When suicidal persons seek help, they typically need support to reduce the intensity of the immediate crisis, manage risk, increase safety and enhance resources. The capacity to provide crisis support to suicidal individuals is a generic service need in suicide prevention.

Role and Effectiveness of Helplines

Rigorous research in the USA has demonstrated the ability of telephone crisis lines to effectively fulfil a vital role as part of the community's crisis response capability to reduce suicide. One of these studies demonstrated that crisis line contact did help ameliorate current distress and manage immediate suicide risk[10]. A further study found a significant reduction in suicidality during the call and identified a further reduction in hopelessness and psychological pain at follow-up[11]. While contact with a helpline did not eliminate suicide thoughts for all callers, it did help reduce suicidal intensity, mobilise emergency service responses when needed and facilitate access to further help. The follow up studies of callers have shown that these services are reaching seriously suicidal people that these individuals are often following the advice and referral options provided to them and finding these actions helpful, and that for some there is a reduction in suicidal ideation.

The response from state mental health directors in the USA to this emerging evidence and the imperatives of providing national access to service for suicidal persons has been to recognise formally the role and contribution of a national crisis helpline in suicide prevention. Their recommendation that follows reflects this:

The public mental health system should support and collaborate with crisis hotlines to ensure individuals at risk for suicide, including those who have made a suicide attempt, can readily access high quality crisis support services.[12]

[10] Mishara, B.L.; Chagnon, F., Daigle, M., Balan, B., Raymond, S, Marcoux, I, Bardon, C., Campbell, J.K. & Berman, A. (2007). Which helper behaviors and intervention styles are related to better short-term outcomes in telephone crisis intervention? Results from a silent monitoring study of calls to the US 1-800SUICIDE network. *Suicide and Life-threatening Behavior, 37* (3), 308-321.

[11] Gould, M.S., Kalafat, J., Harris Munfakh, J.L. and Kleinman, M. (2007). An evaluation of crisis hotline outcomes: Part II Suicidal callers. *Suicide and Life-threatening Behavior, 37* (3), 338-352.

[12] National Association of State Mental Health Program Directors (March 2008). Suicide Prevention Efforts to Individuals with Serious Mental Illness: Roles for the State Mental Health Authority.

Advantages of helplines are that they can provide:

- Non-judgmental access to services 24 hours a day, seven days a week;
- A response across a prevention and treatment spectrum including providing crisis intervention and (sometimes) longer term support, coordination and service provision;
- Referrals to mainstream and specialist health services, including mental health services;
- A capacity to increase immediate safety during a period of acute suicide risk and;
- Development of enhanced suicide intervention knowledge and competencies in both professional and volunteer caregivers.

Service Usage – Lifeline 13 11 14

Lifeline 13 11 14 is the only national helpline of its nature in Australia. The service is widely regarded as an accessible service for suicidal people and Lifeline as an organisation and brand has a 97% recognition and similar level of trust in the Australian community.

Lifeline receives about 50 calls a day directly relating to suicide, and approximately 3-4 of these calls are from someone who has already initiated the act of suicide.

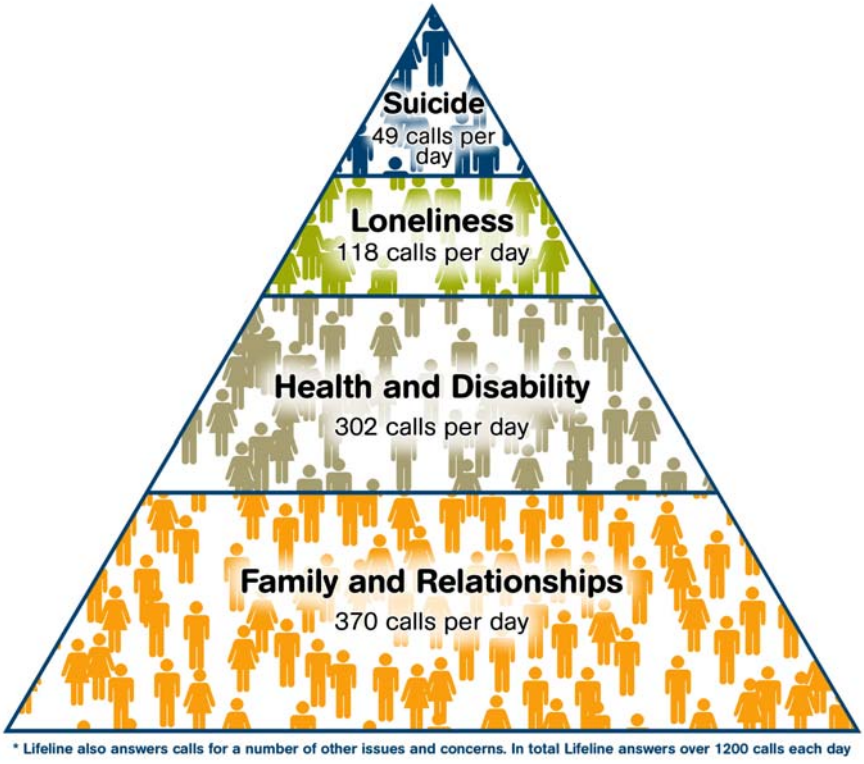
Lifeline 13 11 14 is mentioned in the media and by professionals such as psychiatrists, psychologists, counsellors, health workers, family workers and generally in the community as a point of contact for anyone in crisis.

Each year, Lifeline 13 11 14 receives approximately 450,000 calls – over 1,200 a day. Of these calls, many are related to family and relationship issues, loneliness and social isolation, and health and disability. Approximately 5.8% of the calls involve an identified high risk of suicide. Approximately 3-4 of these suicide calls are from someone who has already initiated the act of suicide.

As with international trends for helplines, suicidal people do phone Lifeline 13 11 14, even when every other service and support option has been explored.

Lifeline has recently undertaken analysis of the call to 13 11 14 where a high risk of suicide is identified. This analysis found that 76.2% of these calls related to the caller's suicidality, 7.6% bereavement after suicide and 16.8% of calls concerned another person's suicide risk. This indicates that 13 11 14 is not only used by people considering suicide, but that it provides a vital role to support third party care givers. Almost two thirds (64.8%) of the suicide-related calls were from women and 35.0% were from men. More than half of the calls about current suicide thoughts (59.1%) also mentioned prior suicide behaviour, which places these callers at a much higher suicide risk.

The following pyramid represents an approximate number of calls Lifeline receives each day. The issues represented here are all prominent issues discussed with telephone counsellors by callers to Lifeline. This representation shows the flow on effect that these particular issues can have for a suicidal person if not dealt with early on. Lifeline believes in early intervention, and by addressing issues relating to family and relationship problems, health and disability issues, and loneliness, we believe that this in turn can reduce the number of people who think about suicide as an option when these issues are not dealt with.



The reality is that most suicidal people do not want to end their lives because they wish to die, but they are trying to stop the pain of their immediate circumstances. By dealing effectively with issues such as the ones represented above, in effect, we may be preventing someone from getting to the point where they consider suicide.

Current Situation – Lifeline 13 11 14

The National Suicide Prevention Strategy in Australia contains no direct reference or mandated role for Lifeline 13 11 14 – despite the widespread usage, promotion and referral to the service in the community generally, and by health care professionals.

Funding for 13 11 14 service operations is partly met through a mix of Federal, State and local funding, but Lifeline itself continues to provide about two-thirds of the operating cost from fundraising, social enterprise (retail shops) and donations.

No funding has been provided or is currently provided for Lifeline's 13 11 14 service from the National Suicide Prevention Strategy.

Federal Government funding under mental health reform has enabled state of the art technology to be installed nationally and supports service quality improvement – reflecting the focus being given internationally to the service standards, critical processes and supervision/support. A return on investment is possible through operational funding being secured.

The recognition of Lifeline 13 11 14 as a national essential service would also address a single key barrier to people accessing the service – removal of the requirement for the caller to pay towards the call costs. (NB: Mobile phone callers to 13 11 14 are frequently paying higher call costs and the proportion of callers from mobile phones is now estimated to be more than half of all calls.)

Service Enhancement Potential – 1800 SUICIDE

While the effectiveness of helplines in responding to suicidal persons is known, the best means of attracting and enabling persons in a suicidal crisis to contact these services is less well known.

Lifeline's experience under previous Commonwealth and state-funded suicide prevention initiatives has been that dedicated social marketing strategies designed to increase service access to its telephone counselling services contributed to an increase in service uptake of 64% and 150% respectively[13]. However, evaluations also indicated that systemic enablers needed to be sustained for benefits to continue over time. Increased promotion and capacity featured in both studies.

Specific media reference to a helpline is known to attract callers in certain circumstances. The tragic death of actor Mark Priestly in 2008 generated a three-fold increase in calls to Lifeline 13 11 14 in the night and days following a telecast memorial that included reference to the Lifeline 13 11 14 service.

[13]Turley, B., Zubrick, S., Silburn, S, Rolf, A, Thomas, & Pullen, L. (2000a) *Lifeline Australia Youth Suicide Prevention Project. Final Evaluation Report*; Turley, B. (2000b). *Telephone counselling: Victorian suicide prevention field trial*. Unpublished paper.

The benefit of promoting help seeking in a contextual way was also illustrated in a Seattle based study that illustrated how promotion of a help line following a celebrity suicide significantly increased crisis line usage, which in turn helped prevent imitation suicides, with only one possible case of an imitative suicide identified[14].

In July 2006 a scoping study undertaken by Lifeline into a National Suicide Prevention Crisis Line was submitted to the Department of Health and Ageing which had funded the project. This scoping study explored the potential for social marketing of a helpline through deliberate identification as a suicide service, i.e.: Suicide Helpline. It concluded that a trial of a specifically marketed service was warranted to obtain evidence on whether or not more suicidal people – and potentially people who would not phone a more generally promoted service – would seek help.

Lifeline has acquired right to a telephone smart number – 1800 SUICIDE. This number would not replace 13 11 14, but would create a 'dual' access route to the helpline, similar to that in the USA. This smart number would ideally suit a social marketing campaign to encourage help seeking to a helpline by people feeling suicidal. Lifeline believes the return on investment in funds for a trial of this approach would be demonstrated by the knowledge obtained and the ability to consider how service development and promotion could be more effective in Australia.

Service Extension – Follow-up Support

Follow-up with suicidal persons to reduce subsequent suicidal behaviour is among the most consistent findings on effective service types in suicide prevention research in the USA,[15] UK, [16] and Australia[17].

The need to follow-up suicidal persons after an initial crisis contact or hospitalisation has also been identified as a critical element in effective suicide prevention.

For example, one review of 20 studies found that 41% of suicides among those receiving psychiatric treatment occur within one year of being discharged, and 9% within the first day[18]. Other research identifies similar concerns associated with risk immediately after admission and discharge[19].

Opportunities to manage recurrent suicidal crises, monitor progress and maintain treatment are all benefits of follow-up strategies. They recognise that, for many,

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[14] Jobes, D.A., Berman, A.L., Ocarroll, P.W., Eastergard, S., and Knickmeyer, S. (1996). The Kurt Cobain suicide crisis: Perspectives from research, public health and the news media. *Suicide and Life-Threatening Behavior*, *26* (3) 260-271.
[15] Motto, J.A. & Bostrom, A.G.(2001). A randomisd controlled trial of postcrisis suicide prevention. *Psyciatr Serv, 52,* 828-833.
[16] Morgan, H.C., Jones, E.M., Owen, J.H. (1993). Secondary prevention of non-fatal deliberate self-harm: The green card study. *British Journal of Psychiatry, 163*, 111-112.
[17] Aoun, S. (1999). Deliberate self-harm in rural Western Australia: Results of an intervention study. *Australia / New Zealand Journal of Mental Health Nursing, 8*, 65-73.
[18] Prikis, J. & Burgess, P. (1998). Suicide and recency of health care contacts. A systematic review. *British Journal of Psychiatry, 173* (6), 462-474.
[19] Qin, P & Nordentoft, M. (2005). Suicide risk in relation to psychiatric hospitalisation: Evidence based on longitudinal registers. *Archives of General Psychiatry, 62* (4), 427-432; Owens, D., Horrocks, J., House A. (2002). *Fatal and non-fatal repetition of self-harm. British Journal of Psychiatry, 181*, (3), 193-199.

suicidal episodes have acute and chronic elements and acknowledge that transitions into and out of in-patient care are vulnerable times for those who are suicidal and their carers.

In Norway, multidisciplinary chain-of-care networks co-ordinate follow-up for those who have attempted suicide. This framework has been associated with fewer further suicide attempts and better treatment maintenance in areas where it has been implemented[20].

Lifeline received Federal Government project funding from 2005 – 2007 to operate a suicide crisis follow up service for callers to Lifeline 13 11 14. The evaluation of this project showed high levels of satisfaction from callers and impacts on the suicidality of these callers. Willingness and capability of callers to themselves explore other forms of support and access to other services also increased during the follow up period.

While mental health reforms have enabled face to face and phone based psychological services and follow up for suicidal persons, these have to date been more concentrated on a treatment or therapeutic model.

Lifeline believes that a beneficial supplementary service is the provision of follow up personal support for a suicidal person that is built around the feature of a positive helping relationship, i.e.: using the same principles and service processes as a helpline in connecting in a trustful way, providing emotional relief from distress and building coping capabilities with a person.

There is a strong coaching component to follow-up support to assist clients to navigate the mental health system effectively and move through the 'transition zones'. Providing emotional support to address the 'psyche- ache' often experienced by suicidal callers is also key feature. Practice has shown that utilising collaborative problem solving, and enhancing help-seeking capabilities while focusing holistically on the caller using a strengths based approach can increase safety for clients.

Lifeline has a developed and evaluated service model for follow up support for suicidal persons. There is workforce capability and a distributed network of Lifeline service outlets that can enable effective operation of this service model. To date, the availability of funds has restricted Lifeline's ability to provide this follow up service.

Recommendation 6: *Mandate and fund the Lifeline 13 11 14 nationwide 24 hour helpline as an essential suicide intervention service.*

This would enable callers to contact the service without incurring any call costs.

Rationale:

- ***Name recognition****. Lifeline is uniquely associated with suicide prevention in the public mind – more than 91% of Australians identify Lifeline with suicide prevention and the provision of crisis support according to Newspoll data;*

[20] Dieserud, G. , Loeb, M., Ekeberg, O. (2000). Suicidal behaviour in the municipality of Baerum, Norway: A 12-year prospective study of suicide and parasuicide. *Suicide and Life-Threatening Behavior, 30,* 61-73.

- ***Capability.*** *Extensive development of Lifeline's telecommunications infrastructure has developed a unique nationwide service response capability;*
- ***National framework.*** *Standardised Lifeline policies, procedures and training enable a consistent crisis response;*
- ***Community profile.*** *Presence in over 60 locations facilitates local networking capabilities to match the benefits of a strong national profile;*
- ***Service continuity and linkages****. The proposed integrated model has the current capability and development potential to integrate and deliver a service response in three domains critical to safe outcomes - access, immediate crisis management and transition to other services.*
- ***Effectiveness.*** *Plans for independent research and evaluation of service outcomes are currently being scoped and will be implementation ready by mid 2010 for funding consideration.*

Recommendation 7: *Fund extension and service development for 13 11 14 in areas in which its effectiveness in suicide prevention can be enhanced:*

This could include:

- *Funded field trials of a '1-800 Suicide' number (owned by Lifeline) to create a dual access gateway to the Lifeline helpline – recognising some callers may readily self identify as seeking a suicide service;*
- *A funded extension to 13 11 14 for a follow-up service to provide suicidal callers with enabling support and safe-transition to additional services and supports following the initial crisis contact.*

6.2 Lifeline's Experience with Emergency and Health Services

Lifeline is often told of experiences where suicidal people have not been provided with appropriate care by emergency e-health services. The following comments illustrate the difficulties and system failures that can occur for suicidal persons. Many of the personal stories contained in Attachment A to this submission reinforce these comments by individual experiences.

Coordinated Care

Lifeline has seen examples of where a lack of coordinated care between services such as drug and alcohol, mental health, and hospitals can mean that people at risk of suicide do not receive appropriate and holistic care and intervention.

Such a lack of cohesion in the health sector can mean that people requiring help 'fall through the gaps' and the onus of responsibility and care is left to friends, family, or carers. Carers have reported feeling a sense of hopelessness and lack of support.

They often feel frustrated by the inability to access appropriate services for their loved ones, as well as appropriate support for themselves.

Mental Health Clinics

Lifeline is aware of reports of suicides occurring after people have left a mental health care facility. Examples of this appear in a number of personal stories contained in Attachment A. Often the loved ones feel that if this person had received appropriate follow up care, the suicides could have been avoided.

Specific examples include when more than one parent has contacted Lifeline looking for help, because they were worried about the safety of their son or daughter, or because a suicide attempt had been made, and there was no follow up after an initial intervention by a mental health care facility. One parent reported that his son died by suicide after many previous attempts. They did not know how to intervene, and did not know who to ask for help after he was released from the mental health hospital. Their son was suffering from mental illness and was difficult to manage. The impact on this family has left them with feelings of loss, guilt, and shame for not being able to find the right kind of help to prevent the suicide.

It has also been the experience of Lifeline that local Psychiatric Services are unable to attend to people in crisis who are unable to get themselves to the facility. In some areas, Lifeline has reported that local Police have indicated they are “sick of being a taxi service for Psychiatric Services”. This brings about a feeling of helplessness and anger towards inadequate services by the people who require them.

Hospitals

Hospital discharge does not always include a workable discharge plan, and a person at risk of suicide can return home with limited or no supports in place.

The result is often an overburdened community health system or multiple readmissions. In some cases, members of a Lifeline support group, whose loved one had voiced an intention to suicide, had taken them to hospital emergency rooms only to have them discharged hours later. Their loved one suicided either hours or days later. In the hospital setting, there is no non-medical way of getting people through the crises and no capacity to follow up. There needs to be provision for acute non-medical intervention and follow up support for a suicidal person. There is strong research evidence highlighting the critical need for appropriate post-discharge follow-up and the potential benefits that accrue when this follow-up is provided.

Lifeline hears that it is often difficult to have self injury presentations at hospital emergency departments treated and recorded as anything more than for the immediate injury. Consequently the need for follow-up support for potentially high risk people is often not recognised nor put in place. The overall approach to suicide by some in a position of influence is therefore reactionary rather than preventative.

Police

Lifeline's experience is that whilst on the whole the response by the police to suicidal people is good, individual officers may lack the necessary training, experience and skills to adequately assess and assist someone at risk of suicide.

A specific example here is when a member of one of Lifeline's support groups contacted the police after her estranged husband threatened suicide. The police stated to her "If he is talking suicide, he won't do it". She found him dead the next morning.

In some instances police response have been described as "heavy handed" by individuals requiring assistance (particularly those with chronic mental illness) and the treatment they have received from police has further traumatised them.

Lifeline's national complaints system has received a number of complaints regarding how their treatment by police has had a negative impact on them. Examples received include a depressed person being handcuffed to be taken to hospital for treatment; another person was not provided with the time to change from their sleepwear to appropriate clothing before being taken to hospital, and in another instance it was revealed that four police arrived at a suicidal person's home wearing bullet proof vests in the early hours of the morning, and surrounded the house.

These examples demonstrate that an extreme and inappropriate approach is sometimes taken by police. It also demonstrates that universal training in suicide awareness and appropriate responses with suicidal persons is required for police and other emergency services personnel.

Possible solutions are outlined below:

Magellan Health Services - USA

An excellent example of a community program addressing this need is the crisis intervention course for police officers provided by Magellan Health Services in the USA. The initiative is part of an integrated mental health and suicide prevention strategy which features LivingWorks ASIST training and appropriate service linkages[21].

ACROSSnet

ACROSSnet is a Queensland based pilot specially designed for rapid downloading of suicide prevention and help seeking information for rural Australians. The ACROSSnet project was funded by an Australian Research Council grant and is supported and maintained by Lifeline. The ACROSSnet (Australians Creating Rural Online Support Systems) web site aims to help members of rural and remote communities to access information, education and support regarding suicide and its prevention. It is currently funded by the Department of Health and Ageing under the StandBy agreement.

Lifeline believes that resources such as this are invaluable in supporting emergency services and health workers.

[21] *The Arizona Republic,* Oct 15th, 2009.

'Making My Living'

The innovative training project 'Making My Living' was initiated and developed by Lifeline in partnership with two multicultural agencies (i.e. Mulitlink and ACCES). The project goal was to train workers involved with young people from refugee backgrounds, in engagement and managing suicide related issues, contributing to the development of professional knowledge and application. This program will be extended to train workers in immigrant, Indigenous and multi cultural populations. The 'Making My Living' project was funded by the Queensland Department of Communities.

Collaboration with Lifeline

Lifeline is often well placed to work collaboratively with other health services, for the benefit of suicidal people because of the high trust with which Lifeline is held, and the flexibility and creativity it can bring to achieving positive outcomes for people.

One example includes a person who rang Lifeline with chronic suicide ideation, and threatening to jump from a bridge. Emergency services were required on several occasions as an intervention. This became an inappropriate way to respond, so Lifeline initiated contact with the local Mental Health Services, with a view to working collaboratively in caring for this lady. A meeting was convened with the Psychiatrist and case managers, whereby it was agreed that Lifeline become part of the lady's management plan. This proved to work very well for both organisations and was in the best interests of the caller.

6.3 Emergency Service Personnel – Training and Support

Lifeline has worked with many emergency service personnel to provide training, support and debriefing following exposure to a suicide incident. Lifeline also has a role to play for these agencies in providing referrals, as well as accepting referrals.

Lifeline would like to acknowledge a real concern for the potential vicarious trauma for members of our emergency services, who are confronted by suicide in their line of work.

It appears that some emergency service personnel, health, and other community support workers who are the first responders to a suicide incident suffer from compassion fatigue, and at times can have misinformed attitudes towards suicidal behaviours and risk factors. For those who do identify the need for helping the suicidal person, there is often the challenge of having limited, if any, appropriate supports on the spot.

Recommendation 8: *Implement measures such as MOUs and protocols on role clarity and collaboration between non government suicide service providers and agencies such as police, hospitals, emergency and mental health services in responding appropriately to people at risk of suicide.*

The aim is to ensure that persons at risk and carers can rely on a consistent, compassionate local response, nationwide. Process elements could include:

- *Ensuring key services are available and prepared for their role in suicide prevention;*
- *Clarifying service roles within each community;*
- *Establishing protocols, MOUs, handover procedures and other processes that enable continuity of care;*
- *Implementing feedback protocols so that referring agencies are informed about the immediate outcome of their referral;*
- *Ensuring that service providers and the public are aware of what services each agency provides, how they may be accessed and how they work together*
- *Aligning regional and local processes with national priorities and requirements;*
- *Balancing community-based and in-patient services;*
- *Promoting dialog about building collaborative community solutions based on tools such as the LivingWorks, Working Together program.*

Benefits would include:

- *Persons at risk and their carers are clear about where to go for help to keep safe and access further care;*
- *First responders are clear about the expectations and boundaries of their roles and how to facilitate service linkages;*
- *Persons at risk and their carers experience continuity of care.*

Recommendation 9: *Promote collaborative community solutions for suicide prevention based on tools such as the LivingWorks, Working Together program.*

Recommendation 10: *Develop and implement crisis response capabilities for responding to emerging suicide clusters or areas where elevated suicide potential is present following community disasters.*

This could include:

- *Developing guidelines accessible to local community service providers as needed, modelled on local and international examples;*
- *Equipping and mobilise 'crisis teams' to work collaboratively with local communities where increased suicide risk is evident;*

- *Providing support for communities dealing with the aftermath of suicide, working within Australian national bereavement support guidelines.*

Recommendation 11: *Review the provisions and / or interpretations of privacy laws or guidelines as they affect communications between service providers and those caring for persons at risk of suicide.*

Consistent feedback from carers has been that service providers have, on privacy grounds, withheld vital information that could have enabled a more informed response to suicide safety of persons at risk in their care.

Similar provisions to those in professional practice codes about the limits to confidentiality in the presence of threats to life or safety may provide helpful guidance on this matter.

Recommendation 12: *Ensure there is debriefing and supervision for frontline workers (especially emergency response personnel) exposed to a suicide related incidents***.**

7. The effectiveness, to date, of public awareness programs and their relative success in providing information, encouraging help-seeking and enhancing public discussion of suicide (ToR (d))

"Almost straight away I started to regret my decision; what had I done? I hadn't even said goodbye to my family… I think most suicidal people do not want to die; they just don't want to be living their life… I wish people would talk about it; let other people know how real it is. Let them know that suicidal people can be rescued."

- Personal story submitted to Lifeline

"People are afraid of the unknown, of their own lack of education and of doing harm, so they tend to avoid the subject. There is a fear of trying to help someone at risk in case they say or do the wrong thing and actually promote instead of prevent the suicide."

- Personal story submitted to Lifeline

"I know it is the suicidal person that is sick and needs help but surely empowering the closest carers will help reduce the likelihood of a repeated attempt or success."

- Personal story submitted to Lifeline

7.1 Evidence and Issues

The World Health Organisation has recommended that in 'building solutions' for preventing suicide education of both health professionals and the public should start as early as possible and focus on both risk and protective factors[22].

Targets for public education typically include mental health literacy, reducing stigma, increasing understanding of suicide risk factors, improving recognition of suicide warning signs and encouraging help-seeking. Strategies are designed to address knowledge, attitudes and behaviours.Results from various national public educational initiatives around suicide and mental health have been promising, though limited, with an accent more on depression than suicide[23].

A major review of fifteen public education campaigns on depression and suicide in eight countries concluded that 'these programs contributed to a modest improvement in public knowledge of and attitudes toward depression or suicide' but had not yet demonstrated significant increases in seeking care or reductions in suicidal behaviour. Nor had they addressed the extent to which results were sustained over time[24].

Newspoll research 2009 shows that a low proportion of respondents believe that those who were suicidal would tell someone about it

The most helpful clues for a way forward come from a major Australian community study[25]. The study reported positive improvements in mental health literacy between 1998 and 2004, but found that changes were least evident in those with depression who were suicidal when compared to those without depression or suicidality.
Those most at risk were least likely to seek professional help or select appropriate or any treatment.

Newspoll research commissioned by Lifeline in November 2009 shows that a low proportion of respondents believe that those who were suicidal would tell someone about it (23%). This again, shows the investment that needs to be made in suicide awareness education and campaigns within Australia. A significant segment of the community is unable to talk about suicide or suicidality. It could also be argued that

[22] WHO European Minsiterial Conference on Mental Health – Suicide prevention: Facing the challenges, building solutions. Briefingpaper, Helsinki, 2005.
[23] Jorm, A.F., Christensen, H, Griffith, K.M. (2005). The impact of beyond blue: The national depression initiative on the Australian's public's recognition of depression and beliefs about treatments. Aust NZ Journal of Psychiatry, 39, 248-254.
[24] Dumesnil, M.S. & Verger, P. (2009). Public awareness campaigns about depression and suicide: A review. *Psychiatr Serv 60*: 1203-1213.
[25] Goldney, R.D. & Fisher, L.J. (2008). Have broad-based community and professional education programs influenced mental health literacy and treatment-seeking for those with major depression and suicidal ideation? *Suicide and Life-Threatening Behaviour, 38* (2), 129-141.

many respondents are not empowered to 'read-the-signs' of someone who is suicidal and trying to communicate their sense of hopelessness.

The personal stories at Attachment A to this submission starkly illustrate how much has yet to be done to dispel stigma, improve mental health literacy, promote understanding of suicide and build a culture of help-seeking behaviour. Attitudes encountered frequently fostered shame, blame and avoidance of suicide. Depression, anxiety and suicide warning signs were often unrecognised or unheeded.

7.2 Ways Forward

A central issue, then, is deciding who potentially benefits from public education campaigns on suicide while recognising the limitations of these approaches.

Key issues going forward include the following:

- ***Address suicidal people directly.*** While public education campaigns do help improve the overall community climate surrounding mental health care and stigma, strategies targeted at suicidal individuals will be critical in reaching those most at risk and reducing suicides. These more individualised approaches can more directly address issues around help-seeking, problem solving and risk management that are critical to reducing suicidal behaviour.
- ***Refine outcomes for education.*** In proceeding, guidelines for assessment of public education campaigns in mental health and suicide prevention are needed[26]. Further, the nature and level of exposure to key messages required to achieve desired outcomes has yet to be clarified. Reliable ways of assessing the duration of any impact also need development.
- ***Safe talking about suicide.*** Resources for piloting public education approaches at the community level are emerging[27]. Media Guidelines such as those associated with Australia's Mindframe initiative are an example of promoting safe public discourse about suicide.
- ***Reporting on results.*** The need to address suicide as an issue in its own right, rather than simply featuring reports following suicides, has been highlighted[28]. The American Foundation for Suicide Prevention, for example, encourages reporting on stigma, treatment options and trends as a means of enhancing public understanding and informed conversations around suicide.

[26] Dumesnil and Verger, 2005.
[27] Reidenberg, D.J. (2008). Developing and implementing a research based public awareness program at the local level. Powerpoint presentation.
[28] Goldsmith, S.K., Pellmar, T.C., Kleinman, A.M. & Bunney, W.E. (Eds). (2002). Reducing suicide: A national imperative. Institute of Medicine, Washington DC: National Academies Press.

Lifeline believes that a more proactive, systematic approach to public education around suicide be developed within the context of promoting community resourcefulness and mental health literacy. Community-based approaches within a national framework would align local initiatives with national goals and guidelines. It would provide a climate of awareness which complements and optimises strategies specifically addressing individuals at risk.

Recommendation 13: *Commit the authority and resources of the Australian Government to a dedicated community awareness/ social marketing campaign on suicide prevention.*

This would adopt a whole of community approach and should address issues such as:

- *Stigma – encouraging safe, open discussion of suicide;*
- *Information about suicide warning signs*
- *Options and carriers to seeking and providing help*

The LivingWorks program SuicideTALK is recommended as an example of a community development tool on how communities can strengthen life-promotion and suicide prevention activities.

Recommendation 14: *Whenever there is a suicide attempt, ensure that the family members and carers receive awareness training to respond appropriately and facilitate safety.*

The LivingWorks' safeTALK and Applied Intervention Skills Training (ASIST) are recommended as examples of relevant awareness training programs.(See Terms of Reference item e);

8. The efficacy of suicide prevention training and support for front-line health and community workers providing services to people at risk (ToR (e))

"For anyone who has attempted suicide and ends up in Departments of Emergency Medicine (DEM), the medical care is good, as it should be, but the mental damage is sometimes dangerously close to medical malpractice as DEM staff, for the most part, are not properly, or sufficiently trained, and/or knowledgeable in the areas of self harm and attempted suicide."

- Personal story submitted to Lifeline

8.1 The Need

Competence in role appropriate suicide intervention knowledge and skills is a foundational requirement for front-line health and community workers providing services to persons at risk of suicide. Some effective training initiatives have been implemented in Australia over the past decade. However, systematic suicide intervention training to agreed standards across sectors, among emergency services personnel, and within professions has yet to be realised. Further, given the large proportion of the population associated with either workplaces, educational settings, or organised sports, opportunities to train front line workers in these settings present as yet unrealised opportunities to reach many Australians.

8.2 Effectiveness in Reducing Suicidality

A major systematic international review of suicide prevention strategies concluded that gatekeeper education was one of three most promising interventions identified as likely to impact national suicide rates, alongside means restriction and physician education[29].

While it is challenging to demonstrate that reductions in suicidal behaviour are at least partly attributable to training of front line workers, the most comprehensive evaluations of these programs have been in organisational settings where it is easier to manage implementation fidelity and measure outcomes[30].

The US Air Force Suicide Prevention Program has provided the most striking evidence to date of how training contributes to the effectiveness of a comprehensive suicide prevention strategy[31]. The program's implementation was associated with a 33% reduction in risk for suicide.

Importantly, training was embedded in a whole-of-community strategy that targeted stigma (making it 'career enhancing' to seek help). It aimed to strengthen social networks, increase help-seeking behaviours and improve understanding of mental health. The initiative had an early intervention focus to identify problems before they escalated to potentially include suicide risk. It adopted community based, stress management strategies alongside medical services. Leadership support from all levels of the organisation was enlisted.

Regarding the training component, researchers noted that 'measurements of training further support the conclusion that the Air Force fundamentally institutionalised suicide prevention training, which may have had far reaching mental health effects'[32].

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[29] Mann, J.J., Apter, A., Bertolote, J., Beautrais, A., Currier, D., Haas, A., et al. (2005). Suicide prevention strategies: A systematic review, *JAMA*, *294,* (16).
[30] Mann et al., 2005.
[31] Knox, K.L., Litts, D.A., Talcott, G.W., Feig J.C., & Caine, E.D. (2003). Risk of suicide and related adverse outcomes after exposure to a suicide prevention programme in the US Air Force: cohort study**,** *BMJ, 327* (13), 1376-1378.
[32] Knox et al., (2003), p. 1378.

Some training evaluations have focused more on verifying that suicide intervention trainees learn knowledge and skills consistent with program goals that are likely to increase the safety of persons at risk of suicide. This is an important foundational step in demonstrating a program's capacity to reduce suicidal behaviour. Typical immediate outcome measures include identifying persons at risk of suicide, attending to their immediate safety, and facilitating referrals.

In Washington State, participants in a 2-day LivingWorks suicide intervention training program demonstrated better suicide intervention knowledge and ability than a comparison group exposed to a public media campaign. This was particularly the case with respect to a working knowledge of suicide warning signs[33]. This demonstrated the potential value-add beyond public awareness for training front line workers.

Two studies of the LivingWorks Applied Suicide Intervention Skills Training (ASIST) have demonstrated that participants did improve their suicide intervention knowledge as a result of workshop attendance and were significantly better than comparison groups in applying these skills to simulations featuring suicidal persons[34]. A 'substantial increase' in ASIST participants' ability apply suicide intervention behaviours was also noted in Scotland in a sample where 75% were professional workers[35].

Other research has indicated that gatekeeper training has promise in various vocational and workplace settings[36], even though training goals have not always been met[37].

8.3 Alignment with Best Practice and Safe Messaging

The introduction of the Best Practice Registry at the Suicide Prevention Resource Center (Boston) has also provided training developers, providers and consumers with objective measures for assessing program soundness and potential. Standardised criteria enable review of learning processes, the capacity of training to deliver its outcomes and conformity with safe-messaging guidelines. Lifeline suggests that such a registry be established in Australia (see discussion on Terms of Reference h).

Safe messaging is critical not only in applying learning from suicide intervention training, but also in monitoring any potential impact on learners. Safe messaging is critical not only in applying learning from suicide intervention training, but also in

[33] Eggert, L.L., Randall, B.R., Thompson, E.A. , Johnson, C.L. (1997), Washington State Youth Suicide Prevention Program: Report of activities: Seattle WA: Washington State University.
[34] Tierney, R. J. (1994). Suicide intervention training evaluation: A preliminary report. *Crisis: The Journal of Crisis Intervention and Suicide Prevention, 15* (2), 69-76; Turley, B., Pullen, L., Thomas, A., & Rolfe, A. (2000). *LivingWorks Applied Suicide Intervention Skills Training (ASIST): A Competency-Based Evaluation*. Melbourne, Australia: LivingWorks.
[35] Griesbach, D., Dolev, R., Russell, P., & Lardner, C. (2008). The Use and Impact of Applied Suicide Intervention skills Training (ASIST) in Scotland: An Evaluation. Retrieved June 6, 2009, from http://www.scotland.gov.uk/Publications/2008/05/19160035/1
[36] Cross,W., Matthieu, M. M., Cerel, J., & Knox, K. L. (2007). Proximate outcomes of gatekeeper training for suicide prevention in the workplace. *Suicide and Life-Threatening Behavior, 37*(6), 659-670; Matthieu, M. M., Cross, W., Batres, A. R., Flora, C. M., & Knox, K. L. (2008). Evaluation of gatekeeper training for suicide prevention in veterans. *Archives of Suicide Research, 12*(2), 148-154.
[37] Wyman, P. A., Brown, C. H., Inman, J., Cross,W., Schmeelk-Cone, K., Guo, J., et al. (2008). Randomized trial of a gatekeeper program for suicide prevention: 1-year impact on secondary school staff. *Journal of Consulting and Clinical Psychology, 76* (1), 104-115.

monitoring any potential impact on learners. Encouragingly, Gould and colleagues (2005) found no evidence that screening young people for suicide risk precipitated suicidal thinking or behaviour. Another study found that participants' exposure to training about suicide warning signs had no negative emotional impact on them. Nor did it have a more negative impact than a comparison group's exposure to heart attack warning signs[38].

8.4 Ways Forward

Suicide intervention training for community gatekeepers and front-line workers has considerable promise as part of a wider suicide prevention strategy. While results of studies are mixed, there is sufficient and growing evidence of benefit to support a more systematic application of this training.

Key issues going forward include the following;

- Encourage and enable systematic development of role-appropriate suicide intervention training within professional groups and front-line workers;
- Explore strategies to embed suicide intervention training within organisational and workplace settings as part of multi-faceted strategies such as those applied by the US Air Force;
- Identify programs that already have some positive evaluation history as a starting point, while also encouraging evaluation of new initiatives;
- Build best practice in suicide intervention training and inform consumer choice for this training through an Australian based registry that develops evidence based training programs.

Lifeline believes that a more systematic approach to suicide intervention training has the potential to significantly increase identification of persons at risk, attend to their immediate safety and also facilitate their access to appropriate further care.

An appropriately resourced national mandate to implement this training at the organisational and regional level is needed, and would be appropriately mandated as a national strategy. Lifeline can offer its historical experience with suicide intervention training and access to internationally recognised suicide intervention training resources to any Australian initiatives in this arena.

8.5 Lifeline's Experience in Suicide Intervention Training

Since its inception in 1963, Lifeline's suicide intervention training has complemented and supported the provision of its telephone counselling service and associated community activities. As a Registered Training Organisation Lifeline has developed a

[38] Rudd, M.D., Berman, A.L., Joiner, T.E., Nock, M., Silverman, M.M., Mandrusiak, M.., van Orden, K & Witte, T. (2006). Warning signs for suicide: Theory, research and clinical applications. *Suicide and Life-Threatening Behavior, 36* (3), 255-262.

respected profile in suicide intervention training for its own volunteers but also in the wider community and within organisations that have purchased its training services.

A central feature of Lifeline's suicide intervention training capability has been its role as manager of LivingWorks programs in Australia.. Lifeline introduced LivingWorks programs to Australia in 1996 with seed funding from the Commonwealth government, providing access to the most widely used and extensively evaluated international suite of suicide training programs currently available. LivingWorks has played an active role in suicide prevention strategies in Canada, the USA, Norway, Scotland and many other countries.

LivingWorks Programs:

- a competency-based 2-day Applied Suicide Intervention Skills Training (ASIST) workshop in suicide first aid
- safeTALK (suicide alertness for everyone) which has shown early promise in many settings, but particularly in workplace training.
- suicideTALK (centred on community engagement and overcoming stigma)
- suicideCARE (a clinical seminar for front-line caregivers and health professionals)
- Working Together (a community workshop in creating safer community connections)

Recent Commonwealth funding has enabled Lifeline to tailor internationally standardised LivingWorks programs for Australian participants, including the production of local videos.

There are over 300 registered LivingWorks trainers from within Lifeline and many organisations across all states and territories on Lifeline's trainer register. Many of these trainers are in remote regions such as the Northern Territory. LivingWorks programs have potential for much more extensive deployment as part of a nationwide suicide intervention training strategy.

Two LivingWorks programs in particular invite comment as potential resources in any enhanced training strategy.

ASIST

Over 50,000 people have now been trained in LivingWorks' ASIST (suicide first aid) within Australia (Nearly 1 million worldwide).

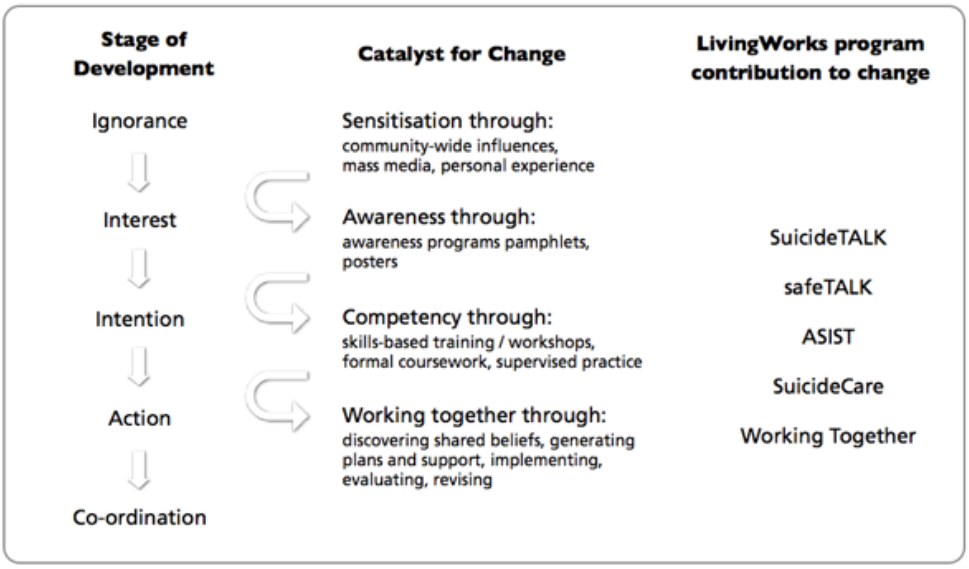
In Victoria, Queensland and the Northern Territory ASIST has played a role in a regional suicide prevention strategies within the National Suicide Prevention Strategy framework. ASIST has also become a key element in suicide prevention training within the ADF, with over 100 of their personnel trained to provide this workshop.

Feedback has strongly affirmed the quality of the ASIST training for trainers and participant materials and the value of the program. Learning congruent with the aims and objectives of ASIST has also been demonstrated in several evaluations along with high levels of satisfaction and confidence to initiate an intervention among participants. In several studies, ASIST has demonstrated its capacity to increase participants' skills in identifying persons at risk of suicide, increasing their safety and enabling links to further help (See discussion of research and evaluation evidence, section 8.2).

There have also been some clear indicators of areas to address in improving program dissemination. These were based on a review of service uptake patterns, a participant feedback study completed in 2007 and a trainer survey conducted as part of this review. Despite its extensive dissemination, ASIST has the capacity for much wider uptake in Australian communities. The potential for utilisation of ASIST for training 'front line workers in emergency, welfare and associated sectors' was identified in the Commonwealth's ***Fourth Mental Health Plan***[39]***.***

As individuals become increasingly aware of the issue of suicide, this awareness is progressively translated into intentional action and achieves the best outcomes if people work together. The following chart outlines how LivingWorks has conceptualised this growth in community engagement and the role of its awareness and training programs in enabling change.

Community Engagement with Suicide Prevention



Source: Adapted from Ramsay, R.,F., Tanney, B.L., Lang, W.A., Kinzel, T., & Tierney, R.J. (2004). *Suicide Intervention Handbook*. Calgary: LivingWorks Education. p. 113

[39] Fouth National Mental Health Plan-An agenda for collaborative government action in mental health 2009–2014 (p. 36).

safeTALK

safeTALK is a half day LivingWorks program designed to increase participants' ability to identify persons at risk and link them to individuals or services able to offer further help. The presentation aims to help participants move beyond avoidance or dismissal of suicide clues and improve their ability to hear or see and respond to persons at risk and link them to people or services able to help.

Whereas ASIST prepares people to engage more fully with suicidal persons to review their risk and develop and mobilise a safety plan, safeTALK enables a briefer engagement – recognising risk, reaching out and enabling referral. These two programs can potentially work together within an organisational or community setting.

The safeTALK training can train larger numbers within a workplace or community to initiate an intervention response while ASIST trained personnel can be a first point of referral – the 'go to' person in a workplace or school (counsellor) that attends more comprehensively to immediate risk and mediates further service linkages, as needed.

The safeTALK program has already played a valued role in some industry settings. A notable example is with the Toronto Transit Authority, where safeTALK training was mobalised with regard to preventing metro suicides. In Australia too, it has been effectively applied to workplace training in industry. The safeTALK program, which now has adapted its learning tools for Australian participants, and is well positioned to offer a substantial contribution to any national suicide prevention training initiative.

Community Capacity Building

Community capacity building has been frequently enhanced by trainees in many professional settings. And Lifeline's volunteer telephone counsellors often utilise their telephone counsellor training and Applied Skills in Suicide Training (ASIST) training, outside of their role as a telephone counsellor in their everyday lives. For example, successful suicide interventions have taken place when telephone counsellors notice that someone who they interact with in their daily lives is exhibiting 'at risk' behaviour. An example of this is described by one of Lifeline's telephone counsellors;

> *"I was eagerly discussing ASIST [training] with a work colleague, talking about how empowered I felt, and how the key message was that it is actually ok to talk about suicide. As soon as I mentioned talking about suicide I noticed a change in his demeanour, and something in my head told me to think carefully about the training I'd just completed. Using my new Lifeline skills – and through just being a friend – we chatted for a while. I noticed, as if with eyes wide open for the first time, feelings and thoughts in him that rang a bell. We were truly connecting for the first time even though we'd already known each other for quite a while. I asked the question I'd just learned it is ok to ask, "Are you having thoughts of suicide?" I felt a very brief moment of panic but then a kind of relief as he said "Yes". I could sense in him a great relief coupled with a kind of disbelief. I was actually ok to talk about this with him! Suicide! He could talk to me."*
>
> *- Lifeline Telephone Counsellor*

There have been many similar reported incidents by ASIST trainees, who indicate that they have identified someone in their lives who is exhibiting at risk behaviour, yet until they had completed training, they did not realise.

Following completing ASIST training, participants reported having the confidence to approach persons potentially at risk and ask them if they were considering suicide; leading to a successful intervention.

Some Lifeline Centres provide ASIST training to services and agencies such as Police, Ambulance, Community Health Workers, Prison staff and Prisoners, Interrelate family services (Mediation for families before court), and Aboriginal medical service workers.

Lifeline has found that suicide prevention training for prisoners to become peer support counsellors works well, because “Top down” implementations tend to have little impact on suicide behaviour in prisons. All leading researchers and commentators agree that unless all participants in the prison system are party to developing and strengthening protective factors then little change will occur[40].

Some Lifeline Centres have also provided Indigenous-specific suicide awareness and prevention training to Indigenous communities, including parents, youth, elders, and community leaders.

Recommendation 15: *Commission and fund systematic gatekeeper training for community leaders and front line workers to be suicide intervention first responders.*

This could include:

- *Provide suicide intervention training in every workplace;*
- *Provide role appropriate suicide intervention training for emergency services and mental health personnel at every location of service;*
- *Provide appropriate suicide intervention training for every secondary and tertiary educational institution.*

Lifeline has the capability to provide national leadership to suicide intervention training in Australia through its network of LivingWorks safeTALK and ASIST trainers present in all states and territories, including rural and remote regions.

Recommendation 16: *Ensure suicide screening and risk assessment training as a basic professional development requirement for all workers in health and human services. This would include:*

- *Identification of role-appropriate levels of training;*

[40] Camilleri, McArther & Webb, 1999. *Suicidal Behaviour in Prisons.*

- *Focus on workers such as physicians, psychologists, family relationship counsellors, social workers and nurses, financial counsellors, drug and alcohol workers;*
- *Establishment of a core unit covering suicide for all health related undergraduate and postgraduate courses (nursing, medicine, psychology, social work) in every Australian tertiary institution.*

Establish and recognise suicide prevention training as a priority professional development activity health, human services and education.

9. The role of targeted programs and services that address the particular circumstances of high-risk groups (ToR (f))

9.1 Need

Programs targeted to high risk groups have an important role in any suicide prevention planning. Strategically, these targeted initiatives are positioned between population-based approaches (such as safe media messaging, restricting access to means and public education campaigns) and interventions designed to focus on individuals showing warning signs of suicide risk.

Strategies targeted at high risk groups aim to prevent the onset of suicidal behaviour among sub-sets of the community known to be vulnerable to suicidal thinking or actions (such as individuals suffering from depression, prison populations or those impacted by trauma and abuse). This targeted approach yields many benefits in directing prevention resources to groups with a higher probability of suicide risk.

However, there are inherent limitations and dangers in over-reliance on this approach which are discussed below.

9.2 Evidence and Issues

The identification of high risk groups rests on strong empirical foundations. For example, research and clinical literature indicates that the suicide risk for people with active mental disorders converges around 7-10 times that of the general population[41].

For prison populations the suicide rate is 9 times higher and 15 times for men alone according to a review of literature by the American Institute of Medicine while alcohol and drug abuse ranked closely behind depression and other mood disorders as the most frequent risk factors for suicide[42]. In practice, many persons at risk have

[41] Tanney, B.L. (2000). Psychiatric diagnoses and suicidal acts. R.W. Maris, A.L. Berman and M.M. Silverman, (Eds.), *Comprehensive Textbook of suicidology* (pp. 311-341). New York: The Guilford Press.
[42] Goldsmith et al., 2002.

overlapping exposure to conditions intensifying suicide vulnerability, such as co-occurring depression and alcohol abuse. Demographic data are also often cited as examples of the relative risk for completed suicide, for example by gender or in specific age-groups. Certain geographic regions also stand out as having suicide rates significantly above the national average, while also having diminished access to resources (see previous discussion in sections 4.3, 4.12). The high rate of suicide in some Indigenous communities has also been noted previously (section 4.13).

Those with a history of prior suicidal behaviour invite particular vigilance about subsequent risk. Studies have indicated that those with prior suicidal behaviour had over 30 times the risk of people in the general population[43]. New Zealand research found that within 5 years, 6.7% of individuals treated for a medically serious suicide attempt had died by suicide while a further 37% made at least one non-fatal suicide attempt. The need for services and initiatives to specifically target this vulnerability has long been recognised. Providing follow-up telephone care for persons discharged from hospital after a suicide attempt was the founding purpose of the Los Angeles Suicide Prevention Centre crisis line in 1958.

Strategies addressing those with prior suicidal behaviour sit mid-point between a high risk group which collectively invites a prevention response and personalised interventions, in that these individuals have already crossed the threshold from general vulnerability and suicide thoughts to suicidal behaviour.

Given evidence of elevated suicide risk for some groups, the need for targeted allocation of resources for prevention activities with these groups is indicated. While some of these groups (such as those in prison) are readily identifiable, others, such as those suffering from depression need first to be identified by self-referral or mental health screening. Once identified, particular vigilance, which includes specific assessment of suicide risk, is a critical prelude to any intervention.

Subsequent treatment and care then needs to target both the mental health condition and the suicidality, along with psycho-social stressors. These stressors may be precipitating or exacerbating the mental ill-health in those already vulnerable, but they may also be a by product of mental illness, such as loneliness, troubled relationships and a disrupted work history.

While the benefits of working proactively with high risk groups are clearly evident, over-reliance on this strategy is dangerous. The presence of one or more risk factors provide solid grounds for particular vigilance about suicide with that group. However, restricting suicide vigilance to these groups will mean that the suicide risk of many individuals will be overlooked, with potentially fatal consequences.

[43] Jamison, K.R. (1999). *Night falls fast.* New York: Alfred Knopf; Cooper, J., Kapur, N., Webb, R, Lawlor, M., Gurthrie, E., Mackway-Jones, K., Appleby, L. (2005). Suicide after deliberate self-harm: A 4-year cohort study. *American Journal of Psychiatry, 162* (2), 297-303.

Moreover, risk factors tend to have a distal relationship to an actual suicidal episode. They provide little information about individuals who are immediate risk and highlight the importance of complementary strategies focusing on suicide warning signs from individuals[44].

Accordingly, suicide intervention training programs, such as ASIST, train participants to set aside assumptions about who may or may not be at risk, and remain alert to any warning signs from any individual, as an invitation to enquire directly about suicide. Further, in Lifeline's experience, a precipitating crisis emanating from a complex interaction of psycho-social stressors and unique personal coping styles is often the first clue to possible suicidality which may or may not be associated with that individual's presence in a high risk group.

In summary, strategies targeted at high risk groups are one of way of allocating prevention resources in places where persons at risk are over-represented, relative to the general population. Strategies to identify and work with these groups are needed. However, there are limitations, dangers even, in placing over-reliance on this strategy. It can only work optimally if population based approaches provide the broad context through safe media messaging, public education and restriction of means. Ultimately, prevention activities must focus on identifying and responding to individuals at risk.

9.3 Ways Forward

Prevention initiatives with these groups include "screening programs, gatekeeper training for 'frontline' adult caregivers and peer 'natural helpers', support and skill building groups for at-risk groups in the population, and enhanced accessible crisis services and referral sources"[45].

Investigations that specifically explore the relationship between mental health conditions or behaviours and suicide would also provide foundations for well-informed action.

Crisis support services and suicide intervention training for front-line workers are a key part of any prevention response in this area and have been discussed elsewhere in this submission (see material in relation to Terms of Reference c and e). They provide intervention options to promote with high risk groups and those who work in settings associated with these groups.

Strategies that increase the likelihood that individuals with mental disorders are identified and treated also provide an essential foundation for a targeted response which needs also to ensure that suicidality is addressed and managed as part of any treatment plan.

[44] Rudd et al., 2006.
[45] Goldsmith et al., 2002.

9.4 Lifeline's Experience with Targeted Programs and Services

Lifeline 13 11 14 has been successful at providing the community with an immediate, non-judgemental, and compassionate source of support. It operates as a generalist service that can be used in conjunction with targeted programs and services, underpinning more specific approaches to target groups.

If Lifeline supports 4 acutely suicidal people every day, this is 1460 per year, which over 46 years, is estimated to be 67,160 lives potentially saved.

At times, Lifeline may be the only support for someone experiencing suicidal ideation, or problems that may result in suicidal thoughts. The value of Lifeline's service to the Australian community is expressed below, by some users of Lifeline's telephone helpline;

"I have used the Lifeline service probably close to 10 times over the past 2 and a half years, since I started treatment for mood and anxiety disorders. I have called when experiencing panic attacks, ideations of self harm, or suicidal ideations. Thankyou for providing an essential community service. Thankyou for employing and training excellent, compassionate volunteers. Thankyou for helping me through excruciatingly difficult mental difficulties which may have landed me in hospital, or worse, without your help."

- Compliment received via email

"I rang from Adelaide today at approx. 2.45pm. I spoke to a female counsellor who identified herself as T.C. I was in a very distressed state and my conversation with T.C. was comforting, informative and empathetic. I was at a real low, and T.C. took the time to talk through my issues, and really understood what I am going through. In fact she inspired me. She gave me hope where I believed there to be none. I now have a practical plan for my future and a better understanding of my situation. I have been desperate, and T.C. has given me a light at the end of the tunnel. I wish to pass on to T.C. my gratitude and my best wishes."

- Compliment received via email

"Dear Lifeline Director,
I'd like to communicate a message of immense gratitude for the support provided by the Lifeline team. For the past few years I've battled the symptoms of depression, chronic fatigue, and have often struggled. The support and care extended by Lifeline counsellors boosted morale and helped me to cope. I've found their assistance more relevant and valuable than face to face counselling. For this reason I've enclosed a donation to assist with financing of this essential work.

Thank you"

- Letter received with donation to Lifeline

If Lifeline supports 4 acutely suicidal people every day, this is 1460 suicidal people per year, which over 46 years, we estimate to be 67160 lives saved. This does not include the other people Lifeline talks to on a daily basis about suicide (where we discuss suicide with up to 50 people per day).

Follow-up Support

The single most important high risk group to target, based on evidence, is people with prior suicidal behaviour. Lifeline also has developed the Lifeline Suicide Crisis Support Program (LSCSP). This program provides follow up support for suicidal callers to Lifeline's 24 hour crisis line, or for those referred from external sources. Up to 8 weeks of telephone contact with a specially trained telephone counsellor is available. The program offers non-judgmental support through a crisis and focuses on safety planning, seeking appropriate ongoing support and reconnecting with community.

Suicide Bereavement Support Groups

Lifeline runs Suicide Bereavement Support Groups. These groups provide a safe and open discussion of the very real possibility that those who are bereaved by suicide may experience suicidal ideation themselves.

These groups have shared heartbreaking and inspirational stories, where vulnerabilities have been exposed; people have shared sorrows, and coping strategies. In some cases it is clear that these groups have been life savers.

One volunteer Peer Support worker, who is bereaved by suicide themselves, explains what they feel are the benefits of these groups for people bereaved by suicide;

> *"In talking to me, I hope they see that while the loss is always there, I am easily able to participate in life again and find enjoyment. Maybe it helps others to know if I can do this, they too may get their life back one day….to be listened to and to feel truly heard is a gift. It is the beginning of finding hope and peace."*
>
> *- Volunteer Peer Support Worker*

A research project was undertaken by Lifeline to examine the effectiveness of suicide bereavement support groups. Feedback identified important elements of the bereavement group experience to be feeling normal in the group; the information and guidance provided to gain a sense of how suicide bereavement is different to other losses; permission to talk vividly, grieve and disclose fears and guilt about the death; and broader meaning making processes surrounding acceptance or adjustment.

Postvention Support

Debriefing and support services are offered by Lifeline to family, friends, bystanders, witnesses and the wider community who need information, support & referral following

involvement, or being witness to, traumatic events such as a suicide. Sometimes, this is a coordinated response with police.

An example of such debriefing involves Lifeline recently attending a sporting club to provide a postvention service, following the suicide of one of their team members. Lifeline staff engaged with twenty two players and other club members who were impacted. During this intervention two further people were identified as thinking about suicide themselves as a result of the initial suicide. These young people were provided with a safe space to talk, and received access to further information about support services and referrals.

Working with Particular Groups within Local Communities

Lifeline's recent experience with young people who are exhibiting suicidal ideation (particularly in circumstances where another peer has died by suicide in their school), that has proven successful is "Contracting" with them to remain safe and checking in on them on a daily basis, until the urge to attempt suicide has passed. The use of SMS messaging has also proven very successful in checking on young people at risk.

Lifeline has developed resource kits which are distributed on a regular basis to funeral homes, schools, community organisations and the general community. These resource kits are often suicide specific in the information they provide to recipients.

It needs to be noted that services that are located in buildings with offices do not always reach those that are most at risk and need immediate help. Those programs and services that go to where the people are have the best chance of being able to intervene when needed, and to connect that person at risk to further care. People in need will not always (or ever) walk into a Lifeline Centre, a doctor's office, or mental health professional's clinic. Lifeline has provided in some locations outreach workers who check in with people in this less formal, more approachable way. This has been found effective and people trust this approach, they often open up and share their real feelings; often of despair. In this way, an informal catch up can lead to getting people the help they really need in a way that is acceptable to them.

It should be noted that emotional health and wellbeing are key factors in the prevention of suicidality. A great deal of attention is given to risk factors for suicide, but little is given to the preventative factors. Resilient communities need to be established by providing early prevention programs, such as school education programs around emotional health and wellbeing, stress management workshops, and relationship counselling etc.

Supporting Men

Men's health and emotional well-being are a focus for Lifeline. Men are not particularly good at seeking help. As a nation we need to help men to manage their emotional well-being, so that when a crisis occurs they do not resort to substance abuse, violence, or suicide.

Men require earlier intervention strategies. Lifeline runs a particular program called

Dads@Lifeline. An example of the work done by this program is evident in the following story, as told by a Lifeline staff member;

> *"….a separated dad walked into a suburban funeral home to take out a pre-paid funeral plan. In the course of the exercise, he revealed to the Funeral Consultant that he intended to take his own life and this was part of his preparation. Through the sensitivity and intervention of the staff of this funeral home, this dad was referred to, and made contact with the Dads@Lifeline program. This program then proceeded to assist him in the circumstances of his life that led him to feeling suicidal. In trying to describe to us how this referral has impacted his life he has used words & phrases like 'I've just found it so helpful,' 'I've found hope,' 'people really do care.' "*
>
> *- Lifeline Staff Member*

The reason this man is still alive today is due to both the intervention of the staff at the funeral home, and the *Dads@Lifeline* team; people in the right place, at the right time, connecting with someone who cares.

Readthesigns Program

Read*the****signs*** is a joint initiative between the Motor Trades Association of Australia Superannuation Fund (MTAA Super) and Lifeline Australia. ***Read****the****signs*** is aimed at promoting help-seeking and suicide prevention among the members of a particular industry group – the retail motor trades and allied industries. The program comprises a communications campaign, awareness sessions for apprentices and self-help resources.

Mental health and suicide prevention awareness sessions are provided to motor trade apprentices in South Australia, ACT, NSW and Victoria. The purpose of these workshops is to increase the level of skills for apprentices in recognising and responding to people who may not be coping, or at risk of suicide, and to assist in linking them with professional and community services. In this way the ***Read****the****signs*** campaign raises awareness of suicide within the community and equips those MTAA Super members with knowledge and resources to read the signs of depression and suicide ideation in their colleagues and friends. It equips them with tools to help a mate and resources to help themselves.

MTAA Super have had a 53% reduction in claims related to suicide from 2004-2007 compared with the claims history over the previous nine years. This can be attributed to many factors, including the raised awareness from the ***Read****the****signs*** project, increased skills in identifying issues, and willingness of members to talk about their problems and seek help in times of crisis. It is also a strong example of how an integrated, tailored and holistic approach to suicide prevention can work.

The ***Read****the****signs*** project has made available a compassionate and supportive resource for people who have lost a loved one, friend or colleague to suicide. The

resource is a booklet titled 'Survivors of Suicide, Coping with the Suicide of a Loved One'. To date 6,987 booklets have been distributed.

Lifeline's *Help a Mate* Suicide Awareness and Prevention Campaign

Lifeline has developed and implemented the *Help a Mate* suicide awareness and prevention campaign in 2007/2008 in partnership with the National Rugby League and Triple Eight Racing. This campaign used themes, imagery and Ambassadors from popular sporting codes to appeal to a predominantly male audience, and to promote subtle messages about suicide awareness and help seeking.

The campaign slogans of *"Help a mate stay in the game" (rugby league)* and *"Help a mate stay in the race" (V8 motor racing),* allowed Lifeline to lead into important key messages about a serious issue, in a way that was more socially and personally acceptable to the audience.

The *Help a Mate* campaign was run as an integrated marketing communication campaign which included the dissemination of 80,000 informational postcards with key messages about looking out for suicide risk in friends and seeking help for self and others if required. The campaign also utilised other means of broadcast, print, interactive and online media to communicate with the audience. All informational materials were developed to be visually appealing and easy to understand.

The campaign allowed Lifeline to somewhat normalise the practice of safely talking about suicide and mental health with friends, family, a GP, or support services such as Lifeline's 24 hour telephone counselling line.

Lifeline's Help a Mate has received a great deal of positive feedback and has won multiple state and national not-for-profit marketing awards.

Suggested Approach

Lifeline supports the development, implementation, funding and continual improvement of sustainable targeted initiatives to support individuals and groups at high risk of suicide.

These strategies should:

- Be based on empirical evidence of groups known to exhibit increased vulnerability to suicide such as people with a history of prior suicidal behaviour and those with mental disorders, substance abuse problems or in correctional facilities;
- Address underlying conditions of risk, such as mental disorders, as well as specific management of suicide risk;
- Recognise the ongoing nature of suicidal risk for some persons, requiring continued vigilance and ongoing treatment as well as crisis support;

- Build on learnings from documented effective intervention and follow-up strategies;
- Provide the option for residential care when needed, accompanied by an appropriate discharge and treatment plan;
- Address contextual factors materially affecting risk (such as housing, employment, material aid);
- Include established programs along with innovative pilot initiatives.

Implementation considerations include the following;

- Since provision of these services is foundational to effective suicide prevention, sustainable funding is essential;
- Since social, medical, economic and personal factors contribute to elevated suicide risk, an wholistic care model is required;
- Since targeting high risk groups will never identify all individuals at risk of suicide, this strategy must always be accompanied by broader community initiatives focused on early identification and safe support of suicidal individuals.

Specific areas where innovation and further development of targeted programs could occur are outlined in the following recommendations*:*

Recommendation 17: *Ensure that prevention activities targeting high risk groups are embedded in a broader population strategy and accompanied by early intervention and follow-up with high risk individuals*

Recommendation 18: *Ensure that appropriate follow-up care is provided for all persons who have engaged in prior suicidal behaviour;*

Recommendation 19: *Introduce specific care and support services to accompany an appropriate discharge and treatment plan for suicidal persons;*

Recommendation 20: *Design, trial and develop service models for residential care for suicidal persons in every capital city, including provision for their carers similar to post recovery units offered in other areas of medical care;*

Recommendation 21: *Create service options that address contextual factors materially affecting suicide risk (such as housing, employment, material aid);*

Recommendation 22: *Develop and resource post-release oriented suicide prevention programs in corrective institutions in every state and territory in Australia;*

Recommendation 23: *Develop and implement a suicide prevention and bereavement support strategy for Indigenous persons as a national priority.*
Key implementation issues include:

- *Ensuring that responses are culturally appropriate and recognise diversity among indigenous people as well as common needs;*
- *Engaging indigenous people in the preparation, delivery and evaluation of services;*
- *Offering both community-based and individual approaches;*
- *Integrating suicide prevention strategies with other initiatives among indigenous people that address areas such as health, housing, education and employment;*
- *Taking into account the impact of the National Strategic Framework for Aboriginal and Torres Strait Islander people's mental health, social and emotional wellbeing.*

Recommendation 24: *Establish and implement a national strategy for removing or reducing access to the means of suicide.*

This strategy could address such issues as:

- *Targeting hot spots*
- *Bridge and railway barriers*
- *Safe use of medications*
- *Reducing abuse of alcohol and other drugs*
- *Considering whether any further measures with gun control and motor vehicle safety are needed.*

10. The adequacy of the current program of research into suicide and suicide prevention, and the manner in which findings are disseminated to practitioners and incorporated into government policy (ToR (g))

10.1 The Need

Evaluation and research are essential elements in developing and improving suicide prevention activities. Reviewing effectiveness, identifying promising initiatives and building on what works are foundational steps in saving lives.

Lifeline supports the stronger emphasis in the LIFE framework on seeking the best available evidence for its preventive activities and concurs in the widely held view that much needs to be done to build a sound research agenda. A brief perspective of issues and opportunities in research and evaluation is provided as background to Lifeline's recommendations.

10.2 Evidence and Issues

A fundamental barrier to progress has been the lack of clear priorities for suicide prevention research in Australia. The mapping of research activities, gaps and priorities that emerged from a recent consultative process has provided good foundations for a national research agenda while also meeting gaps in international findings[46].
One outcome of their consultative process has been recommendations about where to focus research initiatives and resources. It called for a greater relative emphasis on intervention studies with persons at risk rather than broad population-based research. It proposed a focus on the full spectrum of suicidal behaviour (attempted and completed suicide) as well as strategies designed to target suicide methods. This call for research on suicidal behaviour and effectiveness of interventions reflects the emphasis practised and encouraged by an American clinician who has had a respected career working with persons who repeatedly self-harm whose work has reported positive research findings on outcomes[47].

Consistent with this theme of intervention research, Lifeline is currently applying Commonwealth funding to the scoping a comprehensive research and evaluation framework for its national telephone counselling service. This will build on working relationships with researchers who have already conducted published research into crisis lines and provide sound foundations for building the evidence base for this sector in Australia.

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[46] Robinson, J., Pirkis, J, Krysinska, K., Niner, S., Jorm, A.F., Dudley, M., Schindeler, de Leo, D, Harrigan, S. (2008). Research priorities in suicide prevention in Australia: A comparison of current research efforts and stakeholder-identified priorities. *Crisis, 29* (4), 180-190.
[47] Linehan, M. M. (2008). Suicide intervention research: A field in desperate need of development. *Suicide and Life-Threatening Behavior, 38* (5), 483-485.

A further research challenge is ensuring a broad-based approach to research methods. A recent Australian review has offered a pragmatic overview of evidence-based research methods, given the barriers to randomised control trials in suicide prevention research[48]. This review identified some empirical foundations for believing that prevention of suicide is possible. It also indicated that good outcomes are likely to result from a combination of community and professional education initiatives as well as management of mental disorders through medication and other treatments.

A further catalyst in establishing evidence-based practice would be to find ways of promoting dialog among consumers, practitioners, and researchers to guide program development, operations and review. Lifeline has proposed the development of an Australian Best Practice Registry as a means of encouraging, educating and reporting on evidence of what works in preventing suicide. This proposal is discussed more fully in the section on Term of Reference 'g' later in this submission.

The collection of stories for this submission also illustrates the powerful way in which people impacted by suicide can help shape the prevention agenda and provide vital clues to what is needed and what works. It commends the value of naturalistic studies that yield insights into the human dimensions of suicide along with analysis of data arising from sound research inquiry.

10.3 Ways Forward

Lifeline's recommendations for research suggest a way forward, guided by the considerations outlined above. Our commitment is to partner with consumers, researchers, practitioners and other stakeholders to strengthen the evidence for identifying prevention approaches that work and continuously working at service improvement in suicide intervention.

Recommendation 25: *Develop and implement a national research and evaluation agenda to review and improve the effectiveness of suicide prevention and postvention activities. Aims are to;*

- *Build the evidence base on effective or promising strategies;*
- *Identify approaches associated with safe outcomes likely to feature prominently in future development;*
- *Ensure that results are widely disseminated to con sumers, providers, planners and funders (See recommendation 18).*

Key elements include the following;

- *Define areas of national interest, guided by Australian and international work already done on establishing suicide prevention research priorities;*

[48] Goldney, R.D. (2005). Sucide prevention: A pragmatic review of recent studies. *Crisis, 26* (3), 128-140.

- *Align the research and evaluation agenda to national priorities in suicide prevention and bereavement support;*
- *Complement scientific research on clinical interventions with social research on the causes and prevention of suicide;*
- *Ensure consumer involvement in developing and implementing research and evaluation.*

11. The effectiveness of the National Suicide Prevention Strategy in achieving its aims and objectives, and any barriers to its progress (ToR (h))

"There needs to be more funding put into keeping people supported in the community, and building the fence to stop people falling off the cliff, rather than paying so much for all the ambulances at the bottom!"

- Personal story submitted to Lifeline

11.1 Need

The Commonwealth's strategic frameworks have provided helpful guidance to suicide prevention activities within Australia over the past decade. However, despite its comprehensive scope and significant achievements, execution of the strategy has often been fragmented and lacks a clear vision for how all levels of government, community stakeholders and consumers can work together in a co-ordinated way to think strategically, plan effectively and achieve good outcomes. Mechanisms are needed to translate the commitment to evidence-based practice into a workable strategy. The financial resources allocated to implementing the strategy are meagre in relation to the scope of the problem, or resources devoted to other similar national issues and measures needed significantly reduce suicides or respond to those dealing with suicide loss.

Lifeline has had the experience with both our suicide bereavement support groups, and the Lifeline Suicide Crisis Support Program (follow up service) where initially a small amount of government funding was provided to trial the programs, yet upon successful completion of the trials, no further funding was allocated. It is Lifeline's experience that there appears to be no mechanism to assess the efficacy of trials/pilots and if successful implement these nationally as a sustainable funded service. Lifeline has chosen to focus on areas for recommendation and comment.

11.2 Evidence and Issues

Lifeline has chosen to focus on two areas arising from reflection on its consumer stories, practice experience and international associations. These relate to the need

for a more integrated collaborative approach to the suicide prevention strategy and the promotion of best practice.

A fundamental challenge faced by all national strategies is how to engage a wide range of stakeholders in an integrated approach. If there is no collaboration at the level of strategic planning and execution, the goal of developing a cohesive approach to service delivery and research is difficult to achieve.

The following examples illustrate the challenge.

The Institute of Medicine (USA) review of international programs highlights the 'need to understand and bridge the differences between medical and other paradigms' as a basic challenge to be resolved in developing a collaborative approach to suicide prevention[49]. Thus, for example, while mental health and medical initiatives are essential to reducing suicide, they need to be combined with approaches that address psychosocial factors, engage whole communities, strengthen social networks and provide crisis support.

A second problem is the lack of vertical integration and engagement of all levels of government in developing and executing the National Suicide Prevention Strategy. While some initiatives are best addressed at the national levels, other strategic elements will be progressed more effectively at the regional or community level.

A third barrier to integration concerns the limited processes or structures for developing systematic, cross sector collaboration. Those collaborations that do exist tend to be ad hoc, related to particular issues or associated with initiatives arising from particular groups. While entities like Suicide Prevention Australia do provide forums for sharing of ideas, programs and research, more substantial collaborative structures and mechanisms are needed to work with governments, stakeholders, communities and consumers around planning, developing and implementing suicide prevention strategy.

These considerations inform Lifeline's recommendation that the establishment of a National Body dedicated to suicide prevention be considered as a foundational step in forward planning for the National Suicide Prevention Strategy. Such independent body needs to have appropriate authority and sufficient resources to integrate and co-ordinate the involvement of all community and government stakeholders, along with consumers and practitioners. It would play a key role in strategic planning and execution as well as program evaluation and research.

11.3 Best Practice Registry

Lifeline supports the emphasis on encouraging and enabling best practice sourced in evidence of effectiveness. We note, however, that **Australia currently lacks a systematic formal mechanism for identifying, enabling and communicating information about best practice.**

[49] Goldsmith et al., 2002.

Lifeline's experience with colleagues in the United States has highlighted the Boston-based, Federally funded Suicide Prevention Resource Center's Best Practice Registry[50] as a potential prototype for introduction to Australia. The process and outcomes of the early stages of the Evidence Based Practice Project have been documented as background to the Registry[51]:

- The Registry provides a framework for identifying and listing evidence-based practices and programs in suicide prevention – including community programs, training and service delivery.
- It also functions as a clearing house for collecting, listing and accessing standards that meet professional consensus-based criteria for best practice. This provides guidance about standards to practitioners and communities who are developing programs.
- A third role is to list suicide prevention programs that exhibit sound learning processes congruent with their goals, are likely to achieve their objectives and adhere to criteria on safe messaging.

Collectively, the Registry provides a source of reliable information for those seeking suicide prevention services such as training. It offers guidance to people seeking to develop and implement best practice activities. It also provides a forum where practitioners and researchers can communicate and learn how they can best work together to promote best practice in suicide prevention.

Importantly, assessments and activities associated with the registry are informed by evaluation specialists. These specialists work with other professional evaluators and researchers to progress the discussion about what constitutes evidence of benefit and good practice in suicide prevention.

While some of these functions are currently provided in Australia, the systematic approach provided by the Boston Best Practice Registry is lacking and would be enabled by such a venture. It could also become a forum for progressing research priorities in suicide prevention within Australia, such as those proposed in a recently completed project[52].

11.4 Ways Forward

Lifeline's recommendations regarding the National Suicide Prevention Strategy have focused on proposals for improving collaborative planning, service integration and the encouragement of Best Practice.

[50] www.sprc.org
[51] Rodgers, P.L., Sudak, H.S., Silverman, M.M. and Litts, D.A (2007). Evidence-based practices project for suicide prevention. *Suicide and Lifeline-Threatening Behavior, 37* (2), 154-164.
[52] Robinson, et al., 2008.

Key proposals are:

- Vertical integration of the National Suicide Prevention Strategy by engaging all levels of government in strategic development and implementation;
- Establishment of an independent, adequately funded National Body that engages government and community stakeholders in developing and executing the National Suicide Prevention Strategy.
- Creation of an Australian Best Practice Registry.

Appreciating the scope, cost and legacy of suicide highlight why more concerted prevention activity is necessary. However, experience in working with suicidal individuals and emerging research evidence of what works affirm that preventing suicide is possible.

Recommendation 26: *Establish and promote an Australian best practice registry to guide service standards and enable evidence based approaches to suicide prevention.*

This publicly accessible Registry would:

- *Operate as a clearing house for evaluation and research;*
- *Collect and disseminate best practice standards, guidelines and resources relating to evaluation and service provision information and advice;*
- *Guide developers of programs and services;*
- *Inform consumer choices about programs and services.*

Recommendation 27: *Ensure that the National Suicide Prevention Strategy is endorsed, funded and implemented by all levels of government (Federal, State and Local).*

The aim is to vertically integrate and engage all levels of government in suicide prevention activities commensurate with their roles.

Recommendation 28: *Broaden support for the National Suicide Prevention Strategy by actively engaging commitment, financial resources and involvement from the corporate and community sectors to complement government involvement.*

The aim is to encourage broad, collaborative community, corporate and government engagement with suicide prevention in Australia.

Recommendation 29: *Create a national body to develop, co-ordinate, implement and monitor the National Suicide Prevention Strategy*

Recommendation 30: *Engage consumers more actively in the development, delivery and evaluation of suicide prevention services.*

This would specifically include:

- *Persons bereaved by suicide*
- *Suicide attempt survivors*
- *Those caring for persons at risk.*

Recommendation 31: *Develop mechanisms to enable pilot project activity shown to have efficacy to be disseminated widely and provided with ongoing funding.*

12. Conclusion

Lifeline congratulates the Senate Community Affairs Committee on its initiative in conducting an Inquiry into suicide in Australia. Lifeline has given top priority to our full participation in the Inquiry.

Our submission brings together the experiences of the 129 people who told us their personal stories with suicide, and the vast experience of our Centres in dealing with issues around suicide. It is also the result of a comprehensive review of the literature and research base and the participation of our own senior people as well as other experts in the field.

The Inquiry Terms of Reference are wide ranging with far-reaching implications. Lifeline has addressed each term of reference with an emphasis on:

- Creation of a national organisation for suicide prevention independent of any specific Government Department
- Substantial increase in the total funding for suicide prevention
- Improved accuracy and availability of data on suicide deaths
- Formal recognition of the Lifeline national helpline 13 11 14 as an essential national service for its role in suicide prevention.
- Significantly greater investment in training in suicide awareness and suicide intervention for professional 'gate keepers', using high quality programs such as LivingWorks' ASIST and safeTALK
- Maintain strategies and programs for high risk groups on suicide, but match these strategies with a commitment to community-based suicide prevention

We wish to thank the Committee for the opportunity to make a submission to the Inquiry, and assure you that Lifeline offers itself as a resource and sounding-board during the Inquiry and afterwards.

13. Key Literature Informing Strategic Thinking and Planning in Suicide Prevention

A selective List

Lifeline's approach to its work and wider prevention activities is informed by a diverse range of literature sources, many of which are cited in its Submission. The following list provides a cross-section of sources which have particular relevance in shaping suicide prevention planning.

Overview

Joiner, T.E. (2005). *Why people die by suicide*. Cambridge, MA: Harvard University Press. [Book].

Tatz, C. (2007). *Aboriginal suicide is different*. Aboriginal Studies Press.

Prevention initiatives and effectiveness

Knox, K.L., Litts, D.A., Talcott, G.W., Feig J.C., & Caine, E.D. (2003). Risk of suicide and related adverse outcomes after exposure to a suicide prevention programme in the US Air Force: cohort study**,** *BMJ, 327* (13), 1376-1378.

Mann, J.J., Apter, A., Bertolote, J., Beautrais, A., Currier, D., Haas, A., Hegerl, U., Lonnqvist, J., Malone, K., Marusic, A., Mehlum, L., Patton, G., Phillips, M., Rutz, W., Rihmer, Z., Schnidtke, A., Shaffer, D., Silverman, M., Varnik, A., Wasserman, D., Yip, P. & Hendin, H. (2005). Suicide prevention strategies: A systematic review, *JAMA*, *294,* (16).

WHO European Minsiterial Conference on Mental Health – Suicide prevention: Facing the challenges, building solutions. Briefingpaper, Helsinki, 2005.

Crisis Intervention and support

Cerel, J., Campbell, F.R. (2008). Suicide survivors seeking mental health services: A preliminary examination of the role of an active postvention model. *Suicide and Life-Threatening Behavior, 38* (1), 30-34.

Gould, M.S., Kalafat, J., Harris Munfakh, J.L. and Kleinman, M. (2007). An evaluation of crisis hotline outcomes: Part II Suicidal callers. *Suicide and Life-threatening Behaviors, 37* (3), 338-352.

Kalafat, J., Gould, M.S., Harris Munfakh, J.L. and Kleinman, M. (2007), An evaluation of crisis hotline outcomes: Part I: Non-suicidal crisis callers. *Suicide and Life-threatening Behavior, 37* (3), 322-337.

Mishara, B.L., Chagnon, F., Daigle, M., Bogdan, B., Raymond, S., Marcoux, I., Bardon, C., Campbell, J.K. & Berman, A.L. (2007). Which helper behaviors ad intervention styles are related to better short-term outcomes in telephone crisis intervention? *Suicide and Life-threatening Behavior, 37* (3), 308-321.

Standards and Best Practice

Joiner,T.E., Kalafat, J., Draper, J. , Stokes, H., Kundson, M., Berman, A.L. and McKeon, R. (2007). Establishing standards for the assessment of suicide risk among callers to the National Suicide Prevention Lifeline. *Suicide and Life-Threatening Behavior 37 (*3) 353-365.

Rodgers, P.L., Sudak, H.S., Silverman, M.M. and Litts, D.A (2007). Evidence-based practices project for suicide prevention. *Suicide and Lifeline-Threatening Behavior, 37* (2), 154-164.

Research

De Leo, D. (2007). Suicide mortality data need revision. *Medical Journal of Australia. 186* (3), 157-158

Goldney, R.D. (2005). Suicide prevention: A pragmatic review of recent studies. *Crisis, 26* (3) 128-140.

Robinson, J., Pirkis, J, Krysinska, K., Niner, S., Jorm, A.F., Dudley, M., Schindeler, de Leo, D, Harrigan, S. (2008). Research priorities in suicide prevention in Australia: A comparison of current research efforts and stakeholder-identified priorities. *Crisis, 29* (4), 180-190.

Silverman, M.M., Berman, A.L., Sanddal, N.D., O'Carroll;, P.W. and Joiner, T.E. (2007). Rebuilding the tower of babel: A revised nomenclture for the study of suicide and suicidal behaviors. *Suicide and Lifeline-Threatening Behavior, 37* (3), 248-263.