EVERYMIND

Youth suicide generally

1. **What makes youth suicide different? Is there value in having a youth suicide-specific prevention plan?**

Everymind, in partnership with Orygen, developed the ***YOUTH SUICIDE PREVENTION PLAN FOR TASMANIA (2016-2020)*** – see: http://www.dhhs.tas.gov.au/__data/assets/pdf_file/0015/214413/151152_DHHS_Youth_Suicide_PPT_WCAG-1.pdf .

A review of the evidence and consultation with young people and stakeholders found that youth suicide was a public health issue that required tailored coordinated approaches, with combined efforts from all levels of government, health care systems, frontline health and community workers, workplaces, schools and other educational settings, community groups, and the media as well as individuals, families and communities.

While young people generally have lower rates of suicide than other age groups in Australia – with the highest rates occurring in men over 85 years followed by men in their 30s, 40s and 50s – suicide is a leading cause of death for young people so tailored approaches are required. Approaches that we suggested in the Tasmanian Youth Suicide Prevention Plan that we wold recommend to other jurisdictions include:

- Start early by focusing on the resilience, mental health and wellbeing of children, parents and families
- Empower young people, families and wider community networks to talk about suicide in ways that are safe and build their capacity to respond to young people at risk of suicide.
- Build the capacity of schools and other educational settings to support young people who may be at risk of suicide or impacted by suicide.
- Develop the capacity of the service system to support young people experiencing suicidal thoughts and behaviours.
- Respond in a timely and effective way to the suicide of a young person to minimise the impact on other young people

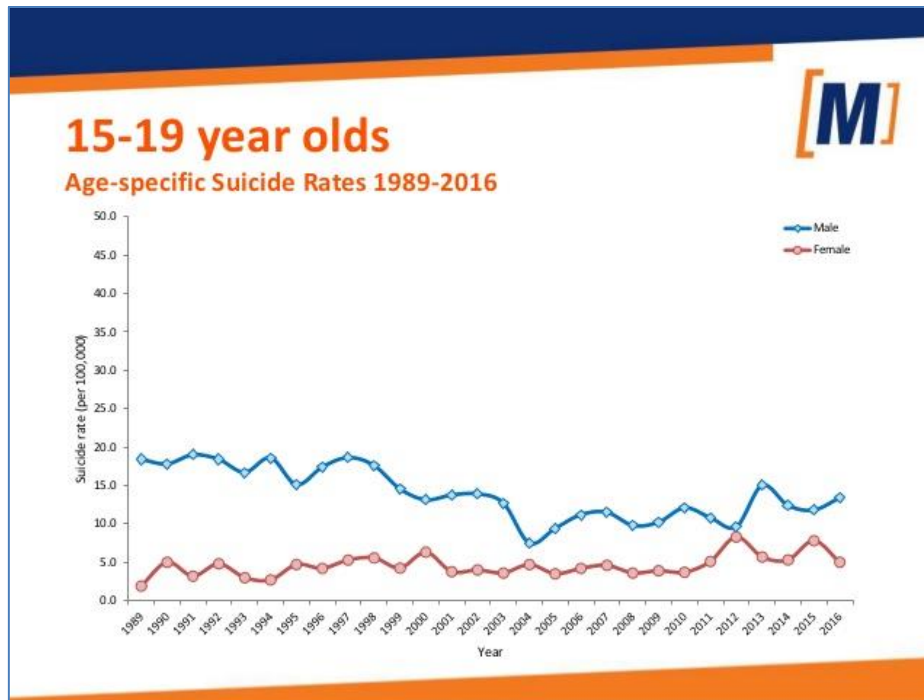
Young people who were involved in the development of the Tasmanian youth strategy, told us:

- Families have an important role in suicide prevention
- Technology is important for accessing information and connecting young people to services
- training teachers and support staff in school is important
- Services need to be responsive to the needs of young people
- They could help if they knew what to say and how to encourage their peers to access support.

2. **Why are the rates of suicide generally higher in young males rather than females? How can current services improve the way boys and young men are engaged and treated?**

Suicide rates are higher for males than females across all age categories and the gap between male and female deaths is actually lowest in younger populations. Over the past 20 years, the gap between male and female youth rates has reduced as outlined in the graph below. While there are

many theories as to why rates of suicide are higher among males (e.g. use of more lethal means, lower levels of help-seeking), less is definitively known.



Latest ABS causes of death statistics (note that more data has been collected since 2006, where previously inquests that took more than 12 months to complete were not included in the data)

3. **The 2016 Orygen report *raising the Bar on Youth Suicide Prevention* stated that the number of suicides by females under 18 had doubled in 10 years. What are the possible reasons for this?**

The numbers going up can be attributed to a combination of factors and we would encourage the enquiry to connect directly with agencies working in youth suicide prevention like Orygen, headspace, ReachOut and others.

It was noted in recent ABS cause of death statistics (http://www.mindframe-media.info/for-media/reporting-suicide/facts-and-stats) that young females' deaths were higher in Aboriginal and Torres Strait Islander communities in particular in WA and QLD, and young females in the general community were also using more lethal means than previously recorded.

Data collection

4. **The NSW Mental Health Commission noted in its submission that the lead agencies in the LifeSpan trial sites are working on improving data collection by conducting data audits and entering into local data-sharing agreements. Could you please summarise how data collection regarding the incidence of youth suicide and attempted suicide is occurring as part of the Newcastle LifeSpan trial?**

The suicide Audits being provided to Lifespan trial sites is being managed by the Black Dog Institute. The local sites are not involved in the data sharing directly so we suggest referring the question to the Lifespan team at the Black Dog Institute for a more accurate response.

5. **A 2016 report by Orygen, *Looking the Other Way: Young People and Self Harm* recommends that the sentinel data collection system for self-harm currently operating in Newcastle be replicated in other sites. Please provide more information about the sentinel data collection system, its benefits and why it should be replicated in other sites.**

Everymind is not involved in the set up or management of the data collection operating through the Calvery Mater Hospital. We suggest following up directly with Orygen for more information on this recommendation.

Effectiveness of current services

6. **Everymind's submission notes that the evidence on the effectiveness of individual interventions is often limited. Can you please comment on the main gaps in the evidence?**

Despite investment in international, national and state suicide prevention strategies, there are still gaps in the evidence regarding the effectiveness of individual interventions upon which to base preventative strategies. Better integration of research with program and service responses over time will help to build and enhance the evidence base for suicide prevention.
https://everymind.org.au/resources/prevention-first

In Australia, and in NSW, there has been a disconnect between programs funded in suicide prevention and research funded in suicide prevention. Our efforts to build evidence for what works would be greatly improved by funding research and evaluation alongside programs to better understand the impact of funded programs, rather than merely reach.

7. **In your submission you call for a 'coordinated multi-sectoral approach to suicide prevention, maximising efforts and reducing duplication' (p2) and a 'coordinated, collaborative, whole-of-government and whole-of-community approach' (p5). What does that look like in practice? What should be improved?**

Reviews of the international evidence have supported the adoption of a multi-faceted approach to suicide prevention. This includes a combination of public health approaches, treatment approaches and community capacity building. The types of interventions that hold the most promise based on research, include:

- Reducing access to means of suicide
- Implementing guidelines related to the reporting of suicide in the media
- Training 'gatekeepers' (including general practitioners, police, teachers, prison staff etc.) to identify and support people at risk of suicide
- Enhancing early access to treatment and referral pathways for people at risk of suicide
- Delivery of evidence-based therapies to people at risk of suicide or experiencing mental ill-health, such as cognitive behavioural therapy
- Postvention interventions to support individuals and communities bereaved or impacted by suicide

Connecting these responses at the local level requires multiple commonwealth and state funded programs and services.

To be effective, our suicide prevention efforts need to involve:

- ✓ People with lived experience of suicidal thoughts and behaviours and their families and carers. They are an important stakeholder and their direct expertise should be utilised in planning, development and review of services and programs.
- ✓ The NSW Government, which funds public health, mental health and alcohol and other drug services as well as community sector organisations who support these services and those with lived experience.
- ✓ Community Sector Organisations who are funded by the NSW and Australian Governments to provide a range of important services across mental health, alcohol and other drug, child and family and suicide prevention areas.
- ✓ The education sector, justice, housing and many other sectors which interact everyday with people who may be at risk of suicide or impacted by suicide.
- ✓ The Australian Government which funds primary care, early intervention, treatment and referral services and national and regional suicide prevention programs. The Australian Government funds Primary Health Networks to better coordinate primary health care delivery and regional suicide prevention programs.
- ✓ The primary health sector that provides services through GPs, mental health nurses and occupational therapists, private psychologists and psychiatrists.
- ✓ Private hospitals and private providers which offer specialist hospital and community treatment programs for those experiencing suicidal thoughts and behaviours.
- ✓ The business community that supports suicide prevention initiatives for their workers and contributes funds to new programs.

In NSW structural supports are needed that allow for effective planning and delivery of suicide prevention responses locally – with KPIs and effective monitoring of progress. While this has been tasked to PHNs in some respects, there needs to be some consideration of how regional planning aligns with smaller regions and how it connects with the state funded services.

8. What improvements can be made in the information and training provided to service providers in regional and rural areas?

There is a big gap in quality and coordinated training and workforce development approaches across rural and metropolitan areas.

There are currently no national or state-based standards for workforces to receive mandatory suicide prevention education or training at either undergraduate level or a part of their continuing professional development. Despite there being a range of evaluated and unevaluated programs offered, there is no currently agreed set of competencies to guide the selection of available packages or to reveal where new training may be required.

There is a variety of suicide prevention training currently available across Australia, which is also reflected in NSW. This ranges from short general awareness sessions for the community to formal qualifications like a Masters in Suicidology.

The most commonly used training programs in Australia and in Tasmania include gatekeeper programs such as ASIST (only available face-to-face), Mental Health First Aid (available online and face-to-face) and more recently QPR online (adapted for Australia through the Lifespan trial). These programs provide general knowledge and skills to support someone who may be suicidal and are generally provided, and most suitable for, community gatekeepers rather than health profressionals.

While there are some exceptions, the current state and national approach to the development and delivery of suicide prevention training for professionals is generally poorly planned, inconsistent and not evaluated. This is reflected here in NSW where there is good work occurring, but limited strategic planning to inform who training is provided to, how it is delivered and whether it aligns with the best available evidence and the current service system.

There has generally been limited attention given internationally to evaluating the effectiveness of suicide prevention training beyond immediate impacts on knowledge. There has also been limited research conducted to test whether training packages developed for communities could be effectively applied to specific workforces such as health professionals or emergency services. This has made it challenging for jurisdictions to confidently plan workforce training as well as broader training for community gatekeepers.

In our view, workforce development in suicide should be a key priority across settings, sectors and locations. We would recommendat that the Centre for Rural and Remote Mental Health comment specifically on strategies to improve responses in rural areas.

9. In your submission Everymind call for an 'alignment between national and state suicide prevention strategies' – what are the current differences between the two strategies? How do you suggest they be aligned?

A successful coordinated response to suicide should prioritise cost-effective and evidence-based approaches that focus on intervening as early as possible with those experiencing suicidal thoughts and behaviours. But it should also look outside the health and other service systems, and think broadly about tackling the factors that may increase or decrease risk in individuals and communities.

With regards to NSW, there are several policy documents that contain activities regarding suicide prevention which do align with the approaches adopted under the 5thMHSPP.

- The New South Wales' *Living Well: a strategic plan for mental health in NSW 2014 – 2024* serves as the overarching framework for mental health and wellbeing for the period of 2014-2024.

- A *Proposed Suicide Prevention Framework for NSW*, was released in August 2015, with an updated Framework in progress.

- The *NSW Aboriginal Health Plan 2013 – 2023* envisions health equity for Aboriginal people that contributes to strong, respected Aboriginal communities in NSW, whose families and individuals enjoy good health and wellbeing.

The Fifth National Mental Health and Suicide Prevention Plan (the Fifth Plan) and its Implementation Plan were endorsed by the Council of Australian Governments Health Council (COAG Health Council) on 4 August 2017. All states and territories now need to ensure their existing policies and strategies are updated to reflect its approaches to support co-ordinated efforts.

While this is a promising step forward to have 5th National Mental Health and Suicide Prevention Plan signed off, it needs to be noted that the Fifth Plan is a Health Minister's Plan and not a Whole of Government Plan. To date it says little about how Commonwealth (including regionally funded PHNs) initiatives and state initiatives will work together at the local level to plan and deliver responses. It also says little about the value of addressing social determinant or taking a primary prevention approach.

In NSW structural supports are needed that allow for effective planning and delivery of suicide prevention responses locally – with KPIs and effective monitoring of progress. While this has been tasked to PHNs in some respects, there needs to be some consideration of how regional planning aligns with smaller regions and how it connects with the state funded services.

10. **The Newcastle LifeSpan trial has now been running for over a year. What phase is the LifeSpan trial up to and are you able to provide an early indication of the results or learnings from this trial?**

Each LifeSpan trial site has been allocated two and a half years, with the first six months designated as planning time. In Newcastle the planning period was extended by 4 months due to delays in receiving information needed for implementation. Consequently the implementation period for Newcastle officially commenced on 1st August 2017.

Given it is so early in the implementation phase there are no formal outcomes that can be reported, however progress has been made on all 9 strategies. It should also be noted that the Black Dog Institute is leading the research and evaluation of all the NSW LifeSpan trial sites.

10. **As part of the LifeSpan trial, a school-based program called YAM, Youth Aware of Mental Health, is being rolled out in public schools in the trial regions. Could you explain how this program works? In what other ways, if any, does the LifeSpan trial cater to children and young people?**

The Black Dog Institute would be best placed to answer direct questions about the selection and roll-out of YAM as much of this has been coordinated at the central level with Department of Educations. Young people will be included in most, if not all strategies in some way.

12. **What specific opportunities are there to improve the mental health of children before age 12? Is there evidence to suggest that interventions before this age are effective in reducing later suicide risk?**

While children suicide is rare and lower rates than all other age groups, it is a leading cause of death in this age group and its impacts can be felt throughout the community.

Even though there is considerable evidence relating to suicide prevention in young people, there is growing recognition of the need to consider suicide prevention activities, focusing on resilience and wellbeing, from the first years of a child's life as well as early intervention and suicide prevention across the lifecycle.

Childhood is regarded as one of the best times to focus on building resilience and preventing mental health, drug and alcohol, and other problems including suicidal behaviour in young people and adults. Interventions targeted at infants, children and their families have been shown to have a

positive impact on health and wellbeing across a person's lifetime and provide a good return on investment. Strategies to improve the mental health and wellbeing of children and families should be prioritised.

Strategies include:

- Prevent and detect all forms of abuse against children – including physical, sexual and emotional abuse.
- Focus on children in out-of-home care and their carers to ensure they have access to programs that build skills and resilience.
- Explore opportunities for children in out-of-home care to have priority access to mental health and health services.
- Develop clear referral pathways and service maps for children and families where a child has an emerging behavioural, conduct or developmental problem to facilitate early intervention by specialist services.
- There is growing evidence to suggest that the delivery of education and awareness programs in schools (that are appropriate for the whole school population) can be effective and are safe to deliver   The Australian Government recently announced the 'Joined up Support for Child Mental Health' initiative to achieve a single integrated school-based mental health program and create more effective interventions for child mental health from early years to adolescence, to be led by beyondblue. It is important for any child strategy to align with the national reform agenda and develop an agreed plan for the coverage of mental health and suicide prevention in primary and secondary schools, colleges and tertiary settings that is evidence-based and fits within both the nationally endorsed curriculum and the role of schools in supporting the mental health and wellbeing of students.

Role of technology

13. **What is your view on the role of technology, including telephone-based services, in helping to prevent youth suicide and the incidence of self-harm, particularly in regional areas? What are the advantages, limitations and risks?**

As part of the Tasmania youth suicide prevention strategy development, both young people Service providers highlighted the need for greater use of technology in suicide prevention activities and when connecting young people to services.

The use of technology as a way of "talking" and connecting is ever increasing. It is important that suicide prevention activities include the use of social media, particularly when supporting young people to talk about suicide.

Evidence is emerging that suggests online platforms, including social media, hold potential in treating and responding to suicidal ideation. The Report of the National Review of Mental Health Programmes and Services strongly recommended integrating and using technology as a preventative and treatment option.

Meanwhile, Everymind, via its *Mindframe* program, is working with Orygen on their Commonwealth funded suicide prevention project, exploring safe messaging social media, which will also include an online campaign.

14. **In its submission Everymind mention the implications for vulnerable youth of user-generated content on social media. Can you expand on what those implications are and**

how they might be addressed? How will the social media guidelines being developed by *Mindframe* be relevant for user-generated content?

Social media platforms such as **Facebook** and **Twitter** offer media and communications practitioners working in mental health and suicide prevention a range of benefits, including a larger audience reach and the ability to promote stories on numerous sites.

However many challenges and risks around online communication still exist.
The *Mindframe* Initiative recognises the important role played by both media and communication managers in providing safe messages about mental health and suicide to the Australian public, and have therefore begun developing guidelines to help ensure that the quality of reporting and portrayal of suicide, self-harm and mental illness is safe, accurate and effective.

In 2013, Mindframe led national roundtable on social media use, with a comprehensive consultation reports describing the common themes from these discussions can be found on the Mindframe website http://himh.clients.squiz.net/mindframe/home/reports

A summary of combined outcomes includes:

- **Current use of social media across sectors:** In terms of social media usage, there was a general consensus among all respondents that social media use was both widespread and extensive. Social media was commonly reported to be used as a marketing tool and as a method of communicating and engaging with target audiences. While there was some evidence to suggest many diverse social media types were currently used, most attendees were of the opinion that for professional purposes, the social media platforms Facebook and Twitter were the most common.

- **Challenges of social media:** When considering social media use, it appeared that there were many consistent challenges across each of the professions. For instance, one of the most prominent concerns regarding social media was the perceived lack of control an individual or organisation had once information was posted on their social media channel. Many respondents from all professions asserted that they were very limited in their capacity to maintain control of any material posted once made available on a public forum. The only feasible methods of control identified were:
  - Staff being extra vigilant when considering posting content
  - Moderating user-generated commentary on social media feeds. All sectors shared similar difficulties regarding moderation of their social media space, such as the lack of guidance on how to moderate effectively, and the limited resources devoted to this need.

15. In relation to *Conversations Matter*, how are these resources distributed and promoted amongst young people? Have you noticed changes in the way in which young people and their families talk about suicide

Conversations Matter is a suite of online resources developed to support community discussion about suicide. The resources provide practical information for communities and professionals to guide conversations about suicide. The resources were the first of their kind internationally and have been developed with the support of academics, service providers, and people with lived experience and community members in New South Wales and across Australia.

Since their launch in November 2013, the recourse has been distributed in online format via various avenues by Everymind, including at conferences and through social media promotion.

Released in time for Mental Health Month (NSW) and Mental Health Week in 20914, **Conversations Matter** featured in the 2014 Glove Box Guide to Mental Health campaign for regional and remote communities in NSW, with tips for community members who may be worried someone they know is thinking about suicide. http://www.conversationsmatter.com.au/news-and-events/conversations-matter-featured-in-glove-box-guide-to-mental-health

The resources adapted in 2016 to work with CALD communities
http://www.conversationsmatter.com.au/news-and-events/launch-cald-resource

Everymind has made several proposals to both states and Federal governments for funding for evaluated dissemination of the resource and updated new versions for youth-specific resources. However, despite the current resources being the only evidence base resources of its type and continued demand from the sector for support, we have not been successful in securing funding.

Answers to Questions on Notice - Everymind

The Hon. Catherine Cusack: Can you tell us which of the studies can give us a bit more guidance on why this is the case (media reporting and suicide deaths), and the nuancing of it between key groups?

Evidence re contagion via mass media

Mindframe: More than 100 international studies have been conducted looking at the link between media reporting of suicide and suicidal behaviour. A critical review, *Suicide in the News and Information Media*, was conducted in 2010 to inform the development of resources for media and other sectors engaged by the *Mindframe* National Media Initiative. The study was an update of an earlier critical review which examined how the media represents suicide and the impact of that representation on attitudes and behaviour in the community[1].

There is strong support for the relationship between media reporting of suicide deaths and increases in completed and attempted suicide rates. These increases cannot be explained by suicides that may have occurred anyway, as they are not followed by commensurate decreases in rates[2].

- For example, a major 1995 study of coverage in Australian newspapers found that rates of male suicide increased following reports of suicide, with actual male suicides peaking on the third day after the story first appeared[3].

The way in which suicide is reported appears to be particularly significant. While evidence for media reporting that can contribute to a reduction in rates is generally lacking, there are some isolated studies that suggest reporting that frames suicide as a tragic waste and an avoidable loss, and focuses on the devastating impact of the act on others, has been linked to reduced rates of suicide.

- For example, a 1997 Australian study of reporting of Kurt Cobain's suicide in a range of media found that rates of suicide among 15-24 year olds fell during the month following the reporting of Cobain's death. Significantly, media coverage of Cobain's death was highly critical of his decision to suicide[4].

A full copy of the report is attached or can be downloaded via this link : http://www.mindframe-media.info/for-media/reporting-suicide/evidence-and-research/evidence-about-suicide-in-the-media

Meanwhile, the University of Melbourne is currently updating this critical review, with findings due in early 2018.

Mr Michael Johnsen: You call for the multi-sectoral approach to suicide prevention, maximising efforts and reducing duplication. What are (agencies) doing about it? What does the coordinated, collaborative, whole-of-government and whole-of-community approach look like? What are the gaps? Given that (agencies) are the drivers of this, what are your perceptions of the gaps?

Collective impact

- LifeSpan is a new, evidence-based approach to integrated suicide prevention. It combines nine strategies that have strong evidence for suicide prevention into one community-led approach incorporating health, education, frontline services, business and the community. https://www.blackdoginstitute.org.au/research/lifespan

- Commonwealth Suicide prevention trials sites http://www.health.gov.au/internet/ministers/publishing.nsf/Content/health-mediarel-yr2017-hunt003.htm