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## Suicide prevention

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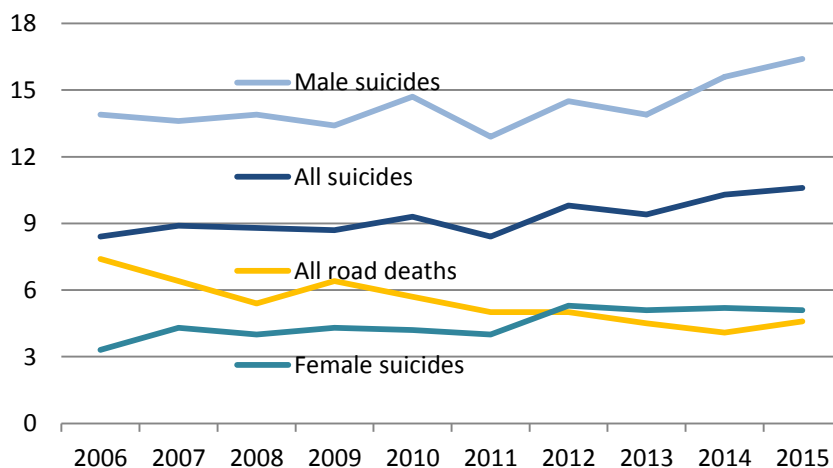
### 1. Introduction

Every day, eight people die by suicide in Australia, including two people in NSW.<sup>1</sup> The majority are males. Suicides are the 13<sup>th</sup> ranked cause of death in Australia, with a higher number of deaths (3,027) than breast cancer (2,967) and skin cancer (2,162).<sup>2</sup> For people aged 15 to 44, suicide is the leading cause of death.<sup>3</sup> Suicides are caused by a “complex interaction of social, economic, personal and situational variables” that “may or may not include mental illness”.<sup>4</sup> The impacts of suicides on families and the community are enormous and long lasting.<sup>5</sup> This paper reviews current NSW Government and national policies on suicide prevention. Mental health policy is only considered where it specifically relates to suicide prevention.

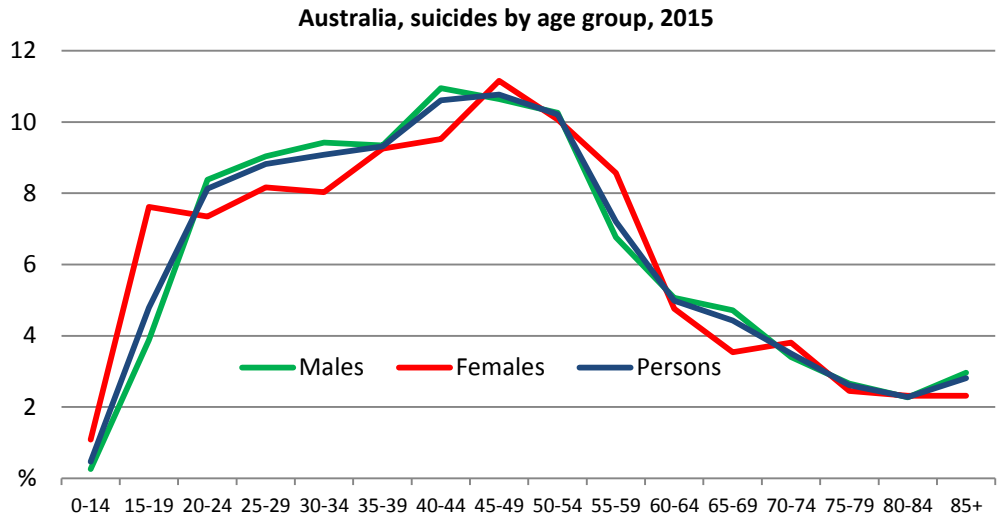
### 2. Suicide rates

In 2015, there were 815 suicides in NSW, including 621 males (76%) and 194 females (24%).<sup>6</sup> To put this into perspective, this was more than double the number of NSW road fatalities in 2015 (350).<sup>7</sup> The NSW suicide rate is 10.6 per 100,000 population. This rate has increased over the last decade, up from 8.4 in 2006 (see chart below). In contrast, the NSW road deaths rate has declined.<sup>8</sup> In 2015, NSW had the lowest suicide rate of all States and Territories (Northern Territory had the highest: 21.0). The national suicide rate is 12.6, up from 10.2 in 2006.

NSW suicide and road deaths, rate per 100,000

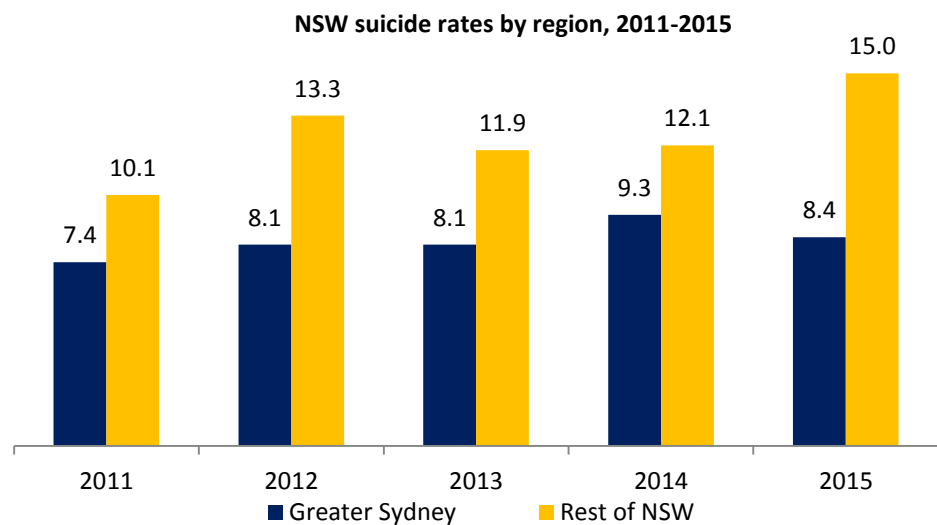


The age-groups that recorded the highest number of suicides were the 40-44, 44-49, and 50-54 age groups (see chart below; this is Australian data as NSW data is not published).<sup>9</sup> While the 85 and over age group had a relatively low number of suicides, it had the highest age-specific suicide rate: i.e. suicides per 100,000 of the population *in that age group*.<sup>10</sup>



In NSW, regional areas have reported higher rates of suicide than Greater Sydney over the past five years (see chart below).<sup>11</sup> This is broadly consistent with rates in regional areas across Australia.<sup>12</sup> Reasons for higher suicide rates in *rural* areas include:

...social isolation, economic stressors, and a lack of available services in rural areas. Other explanations highlight occupational issues related to the farming industry, economic and financial problems, and stressors related to changing climatic conditions. The problematic use of alcohol and drugs and access to lethal suicide methods, such as firearms, may also play a role in explaining the higher burden of suicide in rural areas. Cultural influences on suicide also need to be considered, particularly in areas with a high proportion of Indigenous persons.<sup>13</sup>



Suicide rates for all NSW regions have been published by the NSW Mental Health Commission through a series of [interactive maps](#).<sup>14</sup>

Aboriginal and Torres Strait Islander people are overrepresented in suicides in Australia. In 2015, the suicide rate for Indigenous people (25.5) was more than double the rate for non-Indigenous people (12.5).<sup>15</sup> In the 15-24 age group, the suicide rate for Indigenous people (40.1) was almost four times the rate for non-Indigenous people (10.3).<sup>16</sup> Two reasons are given for high rates of suicide in young indigenous males:

...first, they are overrepresented as vulnerable to suicide risk factors (e.g. alcohol abuse and traumatic exposure) and second, they are the product of wider disadvantage and carry deeper issues of loss of cultural identity and cultural continuity (which would otherwise be a protective factor against suicide).<sup>17</sup>

### 3. Evidence on what works

A 2005 [article](#) reported the results of a systematic review of suicide prevention strategies by suicide experts from fifteen countries.<sup>18</sup> The review examined seven types of interventions (see box adjacent). In summary, the review concluded:

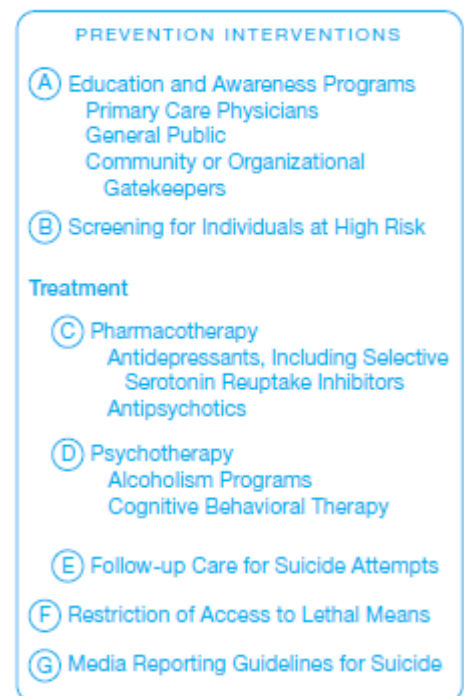
Physician education in depression recognition and treatment and restricting access to lethal methods reduce suicide rates. Other interventions need more evidence of efficacy. Ascertaining which components of suicide prevention programs are effective in reducing rates of suicide and suicide attempt is essential in order to optimize use of limited resources.<sup>19</sup>

A 2016 [article](#) presented a 10-year follow-up systematic review by 18 suicide experts.<sup>20</sup> In summary, the findings were:

Research published since 2005 strengthens the evidence base in several areas of suicide prevention. Restricting access to lethal means can clearly prevent suicide. There have been significant results of school-based awareness programmes in reducing suicide attempts and ideation. The anti-suicidal effects of [the medication] clozapine and lithium have been confirmed but may be less specific than previously thought. Effective pharmacological and psychological treatments of depression are important in prevention as well as education of physicians. There is insufficient evidence regarding possible benefits for suicide prevention of screening in primary care, in public education, and in media guidelines.<sup>21</sup>

A 2013 [literature review](#), prepared for the Australian National Mental Health Commission by the NHMRC Centre of Research Excellence in Suicide Prevention and the Black Dog Institute, stated:

In the last two to three years there have been significant changes in the ways suicide prevention is being approached. First, evidence is accumulating about the effectiveness of various components of a suicide



prevention response. Component programmes with clear evidence of effectiveness include: reducing access to lethal means of suicide, responsible reporting by the media, gatekeeper training in schools and in the military, training of General Practitioners, improving public awareness, and high quality treatment for those with mental illnesses and those who have made suicide attempts. Second, a new idea has emerged – that a systemic approach can comprehensively reduce suicide risk. Evidence is mounting that the best suicide prevention response may be gained from a multi-level, multifactorial, systems-based approach...Third, while vast efforts have been made to reduce suicide in patients in mental health services, these activities have failed to substantially reduce population suicide...<sup>22</sup>

This review suggests that there are more suicide prevention responses that are effective interventions than concluded by the 2016 systematic review (e.g. improving public awareness). This may be due to differing standards of evidence adopted in the two reviews.

In 2016, the [Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project Report](#) was published.<sup>23</sup> The report was based on a literature review, roundtable consultations and discussion at the inaugural National Aboriginal and Torres Strait Islander Suicide Prevention Conference, as well as a meta-evaluation of evaluated, community-led, Indigenous suicide prevention programs. The report identified over 30 success factors for indigenous suicide prevention (see summary table below; factors identified in the meta-evaluation are in blue font).

<b>UNIVERSAL/ INDIGENOUS COMMUNITY- WIDE</b>  In this report 'universal' is used to indicate community-wide responses, not population-wide responses as the term usually indicates	<b>Primordial prevention</b>	<ul style="list-style-type: none"> <li>Addressing community challenges, poverty, social determinants of health</li> <li>Cultural elements – building identity, SEWB, healing</li> <li>Alcohol /drug use reduction</li> </ul>
	<b>Primary prevention</b>	<ul style="list-style-type: none"> <li>Gatekeeper training – Indigenous-specific</li> <li>Awareness-raising programs about suicide risk/use of DVDs with no assumption of literacy</li> <li>Reducing access to lethal means of suicide</li> <li>Training of frontline staff/GPs in detecting depression and suicide risk</li> <li>E-health services/internet/crisis call lines and chat services</li> <li>Responsible suicide reporting by the media</li> </ul>
	<b>School age</b>	<ul style="list-style-type: none"> <li>School-based peer support and mental health literacy programs</li> <li>Culture being taught in schools</li> </ul>
<b>SELECTIVE – AT RISK GROUPS</b>	<b>Young people</b>	<ul style="list-style-type: none"> <li>Peer-to-peer mentoring, and education and leadership on suicide prevention</li> <li>Programs to engage/divert, including sport</li> <li>Connecting to culture/country/Elders</li> <li>Providing hope for the future, education – preparing for employment</li> </ul>
	<b>Clinical elements</b>	<ul style="list-style-type: none"> <li>Access to counsellors/mental health support</li> <li>24/7 availability</li> <li>Awareness of critical risk periods and responsiveness at those times</li> <li>Crisis response teams after a suicide/postvention</li> <li>Continuing care/assertive outreach post ED after a suicide attempt</li> <li>Clear referral pathways</li> <li>Time protocols</li> <li>High quality and culturally appropriate treatments</li> <li>Cultural competence of staff/mandatory training requirements</li> </ul>
<b>INDICATED – AT RISK INDIVIDUALS</b>	<b>Community leadership/ cultural framework</b>	<ul style="list-style-type: none"> <li>Community empowerment, development, ownership – community-specific responses</li> <li>Involvement of Elders</li> <li>Cultural framework</li> </ul>
	<b>Provider</b>	<ul style="list-style-type: none"> <li>Partnerships with community organisations and ACCHS</li> <li>Employment of community members/peer workforce</li> <li>Indicators for evaluation</li> <li>Cross-agency collaboration</li> <li>Data collections</li> <li>Dissemination of learnings</li> </ul>
<b>COMMON ELEMENTS</b>		

### 4. NSW Government policy

In 2010, the NSW Government released the NSW Suicide Prevention Strategy 2010–2015.<sup>24</sup> It is aligned with the national suicide prevention framework: *Living Is For Everyone (LIFE)*, and has six strategic directions:

1. Improving the evidence base and understanding of suicide prevention
2. Building individual resilience and the capacity for self help
3. Improving community strength, resilience and capacity in suicide prevention
4. Taking a coordinated approach to suicide prevention
5. Providing targeted suicide prevention activities
6. Implementing standards and quality in suicide prevention.<sup>25</sup>

Outcomes and actions are listed in relation to each strategic direction. For example, outcomes under the fifth strategic direction include:

- Improved responsiveness to hotspots and environmental factors
- Improved access to a range of support and care for people feeling suicidal
- Systematic, long term, structural interventions in areas of greatest need
- Reduced incidence of suicide and suicidal behaviour in the groups of highest risk
- Improved understanding, skills and capacity of frontline workers, families and carers.<sup>26</sup>

The strategy notes that an independent evaluation of the strategy would be carried out on completion, and that this would be made publicly available.<sup>27</sup> An evaluation report has not yet been published.

On 15 December 2014, the NSW Mental Health Commission launched [Living well: a strategic plan for mental health in NSW 2014-2024](#). The strategic plan has eight actions for suicide prevention:

1. Establish a NSW Suicide Prevention Forum
2. Prepare a NSW Suicide Prevention Implementation Plan
3. Ensure that suicide prevention efforts reflect the unique needs and higher rates of suicide in particular communities and populations, especially young people
4. Work with the Commonwealth and national suicide prevention agencies to improve planning, coordination and delivery of nationally funded or delivered suicide prevention activities
5. Assess the coverage of suicide prevention activities in NSW regions, cities and communities and ensure local responses are supported by local and statewide specialist supports
6. Assess the data needs of local communities and service providers and provide timely reports to meet those needs
7. Ensure that front-line emergency, primary care and crisis personnel have access to good training about responding to suicidal behaviour
8. Assess and improve the identification and response to suicidal people in hospital and community services, and at points of care or service transition, such as discharge from hospital.<sup>28</sup>



The NSW Government [announced](#) its support for the strategic plan and committed \$115 million for [Strengthening Mental Health Care in NSW](#), the first stage of implementing the plan.<sup>29</sup> This package of reforms did not refer to any of the eight suicide prevention actions.

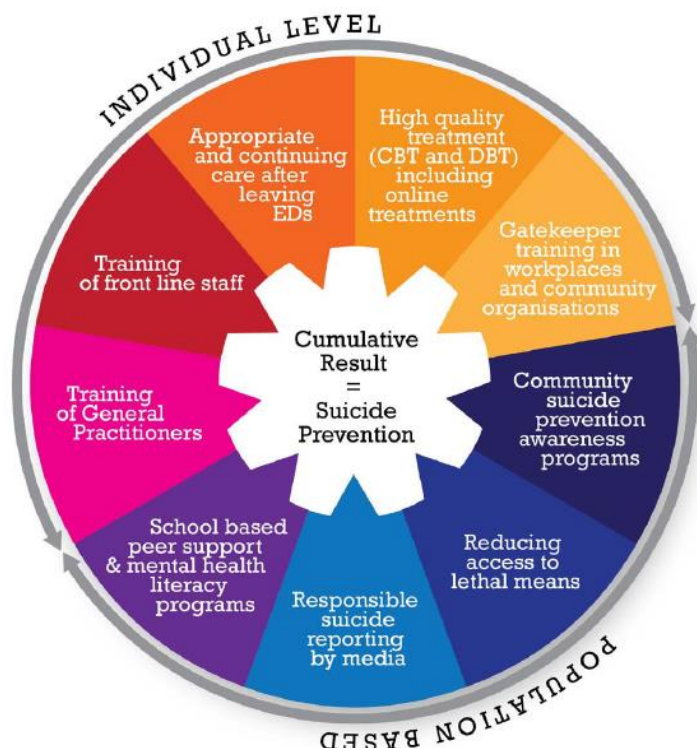
A [one-year progress report](#) on these mental health reforms had one specific mention of suicide prevention. It noted:

Training packages are in progress for non-mental health clinicians across NSW, providing skills to identify and respond effectively to individuals who may be at risk of suicide.<sup>30</sup>

In August 2015, the NSW Mental Health Commission released a [Proposed Suicide Prevention Framework for NSW 2015-2020](#), which was developed by the Centre of Research Excellence in Suicide Prevention and the Black Dog Institute, in consultation with government agencies and stakeholders. The framework “is based on the internationally recognised ‘systems approach’ to suicide prevention”.<sup>31</sup> It has four parts:

1. Implement evidence-based suicide prevention strategies in local areas, using existing community structures and initiatives where possible.
2. Adopt a common evaluation framework across local areas.
3. Engage local communities, such as health services, schools, community agencies, worksites, rural and remote services, and the police, in suicide prevention, and build capacity and readiness across these organisations within the community.
4. Establish good implementation, governance, resources and processes at central and local areas.

The framework lists nine evidence-based suicide prevention strategies, at the population level and the individual level (see diagram below).<sup>32</sup> The idea is that several strategies would be implemented simultaneously.



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A trial is being conducted of the systems approach, through the [Lifespan project](#). The project is being run by the Black Dog Institute, in partnership with NSW Health and others. It is funded by a \$14.7 million grant from the Paul Ramsay Foundation. Four locations have been chosen for the trial:

- Newcastle (commencing October 2016),
- Illawarra Shoalhaven (February 2017),
- Central Coast (May 2017), and
- Murrumbidgee (September 2017).<sup>33</sup>

These locations were selected on the basis of need, community and stakeholder readiness and capacity.<sup>34</sup> Each of the four sites will be supported to implement LifeSpan over a two and a half year period, and this will involve simultaneously implementing all nine evidence-based strategies. Evaluations will measure the impact of the project:

Quantitative data collected will include suicide rate, suicide attempts, hospital presentations and GP visits. Qualitative information will also be collected and will include interviews with consumers and feedback from training.<sup>35</sup>

The Lifespan website states:

Based on the most up-to-date evidence available and drawing from positive results of similar, large-scale suicide prevention programs overseas, this integrated systems approach is expected to prevent 21% of suicide deaths, and 30% of suicide attempts.<sup>36</sup>

In June 2016, as part of the 2016-17 Budget, the NSW Government [announced](#) it is investing \$8 million over four years in a new Suicide Prevention Fund. The Minister for Mental Health, Pru Goward, said:

The contestable fund, available for non-government organisations (NGOs), will encourage both local and scalable initiatives for suicide prevention across a range of points in the system, from early intervention through to crisis care.<sup>37</sup>

Applicants can apply for any suicide prevention activities that align with one or more of the nine Lifespan strategies.<sup>38</sup> Applicants must:

...show evidence that there is a systematic need and/or service gap in their local area, and indicate how the organisation intends to meet the demands of high risk communities.<sup>39</sup>

The Minister stated that the Suicide Prevention Fund would:

...build on a range of initiatives the NSW Government already invests in to address suicide and self-harm in NSW including support of Lifeline, Suicide Risk Training and Mental Health First Aid training.<sup>40</sup>

### 5. National policy

The National Suicide Prevention Strategy commenced in 2000 and developed into a strategy with four interrelated components:

- **LIFE Framework:** sets an overarching evidence-based strategic policy framework for suicide prevention activities

- **NSPS Action Framework:** provides a work plan for national leadership in suicide prevention and policy
- **National Suicide Prevention Program:** the Australian Government funding program dedicated to suicide prevention activities
- **Mechanisms to promote alignment with and enhance state and territory suicide prevention activities:** includes progressing elements of relevant frameworks, such as the Fourth National Mental Health Plan 2009-14.<sup>41</sup>

In 2010, the Senate Standing Committee on Community Affairs published a report [The Hidden Toll: Suicide in Australia](#).<sup>42</sup> It made 42 recommendations for reform across a range of areas. The Commonwealth Government's [response](#) included the *Mental health: Taking Action to Tackle Suicide (TATS) package*, which provided new funding of \$274 million over four years from 2010–11.<sup>43</sup> The TATS package had four strategic actions:

1. **More frontline services and support for those at greatest risk of suicide** – including people who have already attempted suicide or who have severe mental illness. This will mean more psychology and psychiatry services, as well as non-clinical support, to assist people with severe mental illness and their carers with their day-to-day needs (\$115 million);
2. **More to stop suicide and support communities affected by suicide:** providing increased funding for direct suicide prevention and crisis intervention including through boosting the capacity of counselling services such as Lifeline, supporting communities – including Indigenous and school communities – affected by suicide, and to improve safety at suicide 'hotspots' (\$74.5 million);
3. **Targets men who are at greatest risk of suicide – but least likely to seek help.** More targeted crisis support services, workplace programs and anti-stigma and help-seeking campaigns will better support men (\$23.2 million); and
4. **Promotes good mental health and resilience in young people,** to prevent suicide later in life: providing more services for children with mental health problems, as well as in promoting resilience and good mental health in young people – so the children of today are less likely to develop problems later in life (\$61.3 million).<sup>44</sup>

In 2011, the House of Representatives Standing Committee on Health and Ageing published [Before it's too late: Report on early intervention programs aimed at preventing youth suicide](#).<sup>45</sup> The report made ten recommendations including for "research and evaluation to inform best-practice strategies, collaboration, increasing mental health literacy and 'gatekeeper' training".<sup>46</sup> The Government's [response](#) stated (in part):

The Australian Government has embraced suicide prevention activities as a significant component of mental health reform. We are delivering a \$2.2 billion investment in new and expanded mental health reforms over the period 2011-12 to 2015-16, which includes \$696.2 million specifically to support young people through early intervention and prevention mechanisms.<sup>47</sup>

Another response to the 2010 Senate inquiry report was the development of a [National Aboriginal and Torres Strait Islander Suicide Prevention Strategy](#). This strategy was released in May 2013 and was allocated



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funding of \$17.8 million over four years from 2012-13 to 2016-17. Three years later, it was reported that this funding had not been spent.<sup>48</sup>

In January 2014, the Department of Health released an [Evaluation of Suicide Prevention Activities](#). It examined activities funded under the National Suicide Prevention Program and selected elements of the TATS package, from 2006-07 to 2012-13. A key finding was that:

Assessing the effectiveness of NSPP activities was hampered by a general absence of quantifiable outcome measurement by NSPP-funded organisations...[O]utcome measurement is not something that funded organisations have engaged in to any great extent to date. This issue is not unique to the NSPP and has been a challenge for suicide prevention activities throughout Australia and internationally.<sup>49</sup>

In December 2014, the National Mental Health Commission delivered its report [Contributing Lives, Thriving Communities – Review of Mental Health Programmes and Services](#). One of the nine strategic directions for reform was to “reduce suicides and suicide attempts by 50 per cent over the next decade”.<sup>50</sup> The key short-term recommendation in relation to this strategic direction was for the Commonwealth Government to:

Establish 12 regions across Australia as the first wave for nationwide introduction of sustainable, comprehensive, whole-of-community approaches to suicide prevention.

The report proposed further reforms including:

- To work with state and territory governments and key stakeholders to develop a National Suicide Prevention Framework based on Australian and international evidence of what works
- Invite business cases consistent with the framework from regional partnerships, possibly based on Regional Development Australia regions, on co-created models of suicide prevention;
- Use Commonwealth funding models which demonstrate buy-in from local communities through inclusion of contributions from partners, including local councils, business, and community organisations
- Progressively roll the model out across Australia over five years
- Establish nationally consistent routine data collections for suicides and suicide attempts and what services people are accessing, to allow monitoring and evaluation of the outcomes of the investment
- Work with states and territories to establish a national protocol whereby when hospitals discharge a patient from an inpatient service or after a suicide attempt they provide appropriate supports including intensive follow-up services for 30 days
- Promote as standard practice that all frontline staff likely to come into contact with vulnerable people undergo mandatory training on suicide identification and prevention, and that their organisations set as performance targets “zero suicides in our care”.<sup>51</sup>

The Commonwealth Government’s November 2015 [response](#) to the Commission’s report stated that it was committed to moving towards a regional, systems based approach to preventing suicide and that it would:

...move to immediately implement a new national suicide prevention strategy with four critical components:

- national leadership and infrastructure including evidence based population level activity and crisis support services;
- a systematic and planned regional approach to community based suicide prevention, which recognises the take-up of local evidence based strategies. This approach will be led by PHNs [Primary Health Networks] who will commission regionally appropriate activities, in partnership with LHNs [Local Hospital Networks] and other local organisations;
- refocusing efforts to prevent Indigenous suicide; and
- working with state and territory governments to ensure effective post discharge follow up for people who have self-harmed or attempted suicide, in the context of the Fifth National Mental Health Plan.<sup>52</sup>

This strategy is outlined on the Department of Health's [website](#). It notes that "PHNs have been tasked with commissioning regionally appropriate suicide prevention activities and services from 1 July 2016".

In the lead up to the July 2016 federal election, the Coalition [announced](#) a \$192 million plan for mental health care and suicide prevention.<sup>53</sup> As part of this, the Government is establishing 12 Suicide Prevention Trial sites through Australia.<sup>54</sup> Two of the sites are in NSW: one in Western NSW and another on the North Coast. Each trial site will run for three years and receive approximately \$3 million. The Government stated:

With key national partners – such as the Black Dog Institute, beyondblue, *headspace* and other stakeholders – these trials will bring the best evidence-based strategies, models and digital technologies together to better target people at risk of suicide and ensure a more integrated, regionally-based approach.<sup>55</sup>

The plan also included \$12 million for a Suicide Prevention Research Fund.

In October 2016, Australian Health Ministers released the [Fifth National Mental Health Plan: Draft for consultation](#). Suicide prevention is one of the priority areas in the plan.<sup>56</sup> There are five actions:

6. Governments will work together to renew efforts to develop a nationally agreed approach to suicide prevention that aligns their respective activities, and improves identification of people at risk of suicide and the effectiveness of services and support available to them.
7. Governments will work to develop integrated, whole-of-community approaches to suicide prevention at the regional level.
8. Governments will work with Primary Health Networks and Local Hospital Networks to prioritise the consistent and timely provision of follow-up care for people who have attempted suicide or are at risk of suicide, including agreeing on clear roles and responsibilities for hospitals, specialised mental health services and primary care services.
9. Governments will work together to strengthen data collections relating to suicide and suicide attempts to strengthen the evidence base and improve quality of care.
10. Governments will develop suitable public health and communication strategies to better inform the community about suicide and suicide prevention.<sup>57</sup>

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In March 2017, Australian Health Ministers [agreed](#) that this plan will re-emphasise its objective of Suicide Prevention and will therefore become the *Fifth National Mental Health and Suicide Prevention Plan*.<sup>58</sup>

In the [Commonwealth Budget 2017-18](#), new funding for suicide prevention included \$9 million over three years for the States and Territories to prevent suicide at high risk locations through projects such as fencing and lighting;<sup>59</sup> \$2.1 million for Lifeline, and \$9.8 million to fund pilot programs to improve mental health services and suicide prevention for veterans.<sup>60</sup>

On 28 May 2017, the Commonwealth Government [announced](#) funding of \$43 million for 17 organisations under the National Suicide Prevention Leadership and Support Program (formerly the National Suicide Prevention Program).<sup>61</sup> Also announced was \$3 million for the Black Dog Institute to support the 12 Suicide Prevention Trials; and \$1 million to support mental health and reduce suicide in the health workforce.

### 6. Stakeholder views

In September 2014, the National Coalition for Suicide Prevention, a group including 29 member organisations, released [One world connected: an assessment of Australia's progress in suicide prevention](#). The report rated Australia's performance across ten areas, using a traffic light rating system. The summary of Australia's performance is set out below.

Strategy, oversight and coordination		Creation of a national strategy to prevent suicide. Establish institutions or agencies to promote and coordinate research, training and service delivery in respect of suicidal behaviours. Strengthen health and social system responses to suicidal behaviour.
Data (Surveillance)		Increase quality and timeliness of national data on suicide and suicide attempts. Support the establishment of an integrated data collection system which serves to identify vulnerable groups, individuals and situations.
Means restriction		Reduce the availability, accessibility and attractiveness of the means to suicide (e.g. firearms, high places). Reduce toxicity/lethality of available means.
Media		Promote implementation of media guidelines to support responsible reporting of suicide in print, broadcasting and social media.
Training and education		Maintain comprehensive training programs for identified gatekeepers (e.g. health workers, educators, police). Improve the competencies of mental health and primary care providers in the recognition and treatment of vulnerable persons.
Access to service		Promote increased access to comprehensive services for those vulnerable to suicidal behaviours. Remove barriers to care.
Treatment		Improve the quality of clinical care and evidence-based clinical interventions, especially for individuals who present to hospital following a suicide attempt. Improve research and evaluation of effective interventions.
Crisis intervention		Ensure that communities have the capacity to respond to crises with appropriate interventions and that individuals in a crisis situation have access to emergency mental health care, including through telephone helplines or the internet
Postvention		Improve response to and caring for those affected by suicide and suicide attempts. Provide supportive and rehabilitative services to persons affected by suicide attempts.
Awareness and Stigma reduction		Establish public information campaigns to support the understanding that suicides are preventable. Increase public and professional access to information about all aspects of preventing suicidal behaviour. Promote use of mental health services, and services for the prevention of substance abuse and suicide. Reduce discrimination against people using these services.

A poor rating (red) was given in two areas: “strategy, oversight and coordination”, and “crisis intervention”. The report stated:

The strategic approach to suicide prevention in Australia is piecemeal, uncoordinated and overly biased on activities falling under the remit of the Department of Health, especially mental health.<sup>62</sup>

With respect to crisis intervention, the criticism included:

...no national protocols, or state/ territory arrangements, exist to establish linkages between crisis lines and crisis support services with the mainstream hospital and health services, and with mental health professional services.<sup>63</sup>

Suicide Prevention Australia’s [2016 Election Manifesto](#) called on the incoming Commonwealth Government to take four steps:

1. Support the shared goal of halving suicide in ten years
2. Cement Australia’s ongoing commitment to suicide prevention by passing a National Suicide Prevention Act
3. Establish the National Office for Suicide Prevention
4. Establish the National Suicide Prevention Research Fund

In February 2017, following a National Coalition for Suicide Prevention workshop, Suicide Prevention Australia released [A strategic framework for suicide prevention: Consultation paper](#). The paper stated that this strategic framework would contribute to the Federal Government’s development of a national suicide prevention plan. The paper asks “where do we want to be in 2025” and, in brief, it sets out the following six outcomes:

1. A whole system approach to suicide prevention
2. A properly resourced and funded suicide prevention system
3. A whole of community support and engagement model
4. A ‘Person centric’ and integrated approach in service delivery
5. High quality services through standards and regulatory framework
6. A robust ‘Knowledge to Practice’ system

In December 2016, Orygen, the National Centre of Excellence in Youth Mental Health, released a report [Raising the bar for youth suicide prevention](#), 2016. The report presents 17 recommendations across a range of areas for youth suicide prevention. In brief, these are:

1. National leadership and coordination is needed
2. A system of youth mental health care should be built that responds early and effectively to suicide risk among young people
3. Regional responses should be developed that meet the needs of young people
4. Government and service commissioners should prioritise a commitment to using technology in a proactive way
5. Responses in education settings need to reflect emerging evidence that suicide prevention programs can be delivered safely to students

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6. Postvention programs are important and should be included in both community-based and school-based youth suicide prevention responses.
7. Gaps and barriers in youth suicide prevention research and data collection need to be addressed.

### 7. Conclusion

Suicide is a major public health issue; the rate of Indigenous youth suicide is particularly alarming. Despite the existence of State and national strategies, over the past decade the suicide rate has increased in NSW (by 2.2 per 100,000) and nationally (by 2.4 per 100,000).

In recent years, there have been several major reports and policy developments, including the NSW Government's *Living Well: A Strategic Plan for Mental Health in NSW 2014-2024*, and the Commonwealth Government's new *National Suicide Prevention Strategy*. A *Fifth National Mental Health and Suicide Prevention Plan* is being finalised. The *Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project Report* will assist in implementing the *National Aboriginal and Torres Strait Islander Suicide Prevention Strategy*. Perhaps the most interesting development is the trial of a "systems based" approach to suicide prevention in selected regions in NSW and Australia. Recently, a NSW Parliamentary Committee established an [inquiry](#) into youth suicide.

Various stakeholders have called for a range of policy reforms including adopting a goal of halving the number of suicides in ten years, improving national leadership and coordination, and building a system that responds early and effectively to suicide risk among young people. It remains to be seen whether these reforms will be adopted and what progress can be made in suicide prevention in the years to come.

[Lifeline](#) 13 11 14

[Suicide Call Back Service](#) 1300 659 467

[Kids Helpline](#) 1800 55 1800

[Social and Emotional Wellbeing and Mental Health Services in Aboriginal Australia](#)

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<sup>1</sup> ABS, [3303.0 - Causes of Death, Australia, 2015](#), 28 September 2016

<sup>2</sup> ABS, [3303.0 - Causes of Death, Australia, 2015](#), 28 September 2016

<sup>3</sup> ABS, [3303.0 - Causes of Death, Australia, 2015](#), 28 September 2016

<sup>4</sup> National Mental Health Commission, [Contributing Lives, Thriving Communities - Review of Mental Health Programmes and Services](#), 30 November 2014, [Volume 2](#), p111. In relation to mental illness, see also S McPhedran, [Suicide prevention takes more than 'treating depression'](#), *The Conversation*, 26 June 2013

<sup>5</sup> For a study on the impact of suicide on other persons, see Suicide Prevention Australia and University of New England, [The ripple effect: understanding the exposure and impact of suicide in Australia](#), 2016

<sup>6</sup> ABS, [3303.0 - Causes of Death, Australia, 2015](#), 28 September 2016. Note that data for 2015 is preliminary, not finalised data.

<sup>7</sup> NSW Centre for Road Safety, [Crash and casualty statistics – general view](#), [online]



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