

1. INTRODUCTION AND CONCEPTUAL OVERVIEW



Each suicide is a tragic and unique event. Death by suicide reflects an intensely personal set of circumstances for the individual, their family and loved ones. The tragic reality is that every two days, three Victorians end their lives by suicide.

Suicide is now the leading cause of death due to injury in Australia, ahead of motor vehicle accidents and homicide.

It is estimated that each week in 1995, an average of two young people in Victoria died by suicide. Of the 107 young people aged between 15 and 24 years who died by suicide in that year, 74 per cent were young men. Although the overall rate of suicide in Australia has remained constant for 100 years, the rate of suicide for young men has tripled since 1960.

This is not just a Victorian or an Australian problem. According to the World Health Organisation (WHO), suicide is now one of the 10 major causes of death in developed countries. Rises in suicide among young people, especially young men, is a growing international trend.

Most young people successfully negotiate the transition from adolescence to become well-adjusted adults. Nevertheless, over the last 30 to 40 years we have witnessed a significant decline in many indicators of the wellbeing of young people:

- A growing body of research suggests major depressive illness is becoming more widespread among the young in western societies.
- Self-inflicted injuries have risen substantially, especially among young women aged 15–29 years.
- Illicit drug use and alcohol abuse are more prevalent among the young, particularly young men, and contribute to the increase in depression.
- Excessive dieting and eating disorders, such as anorexia nervosa, have increased among teenage women.
- Employment opportunities for young people have reduced significantly, and those under 30 years of age make up just under half of all unemployed people.

Over the past five years, the Victorian Government has sought to improve the wellbeing of young people by implementing a number of strategies to develop a sense of purpose, self-respect and confidence among young Victorians. These include introducing the *Youth Development Program* in schools, establishing a *Youth Council* and developing the *Turning the Tide* initiatives to combat the misuse of drugs in the community.

In this context, the Premier and the Minister for Health established the Suicide Prevention Task Force (Task Force) in January 1997 to conduct an intensive public investigation into the nature and extent of suicide, particularly youth suicide, in Victoria. The terms of reference and membership of the Task Force are set out in appendices 1 and 2 of this report.

From the terms of reference, the Task Force developed a broad goal and objectives to give direction to its work. These are outlined below.

GOAL/OBJECTIVES

To produce a report for the Premier and the Minister for Health that identifies and brings together Victorian information to:

- Establish the best available information on the incidence and nature of suicide in Victoria.
- Identify the strengths and weaknesses of existing suicide prevention responses and set out practical ways to strengthen responses from all sectors of the service system and the broader community.
- Present an approach that can optimise the collective response of the service system, and the broader community, within an integrated suicide prevention framework.

The Task Force pursued this plan, bearing in mind the need to identify specific responses as they apply to younger Victorians, older Victorians, and Victorians living in rural communities.

1.1 TASK FORCE ACTIVITIES

In developing responses to suicide in Victoria, the Task Force listened to the people most directly affected: families of people who had died by suicide, people who had attempted suicide, the service providers and community organisations.

The Task Force undertook a range of activities to ensure it maximised the opportunity for community and expert input. Major activities included:

- Advertisements, calling for community and expert submissions to the Task Force, were placed in the major metropolitan newspapers, local, regional and ethnic newspapers during February 1997. The deadline for written submissions was extended to 19 March 1997. Many additional submissions were presented to the Task Force during the community consultation process in April.
- Fifteen community consultation meetings were held in metropolitan Melbourne and regional Victoria during March and April 1997.
- An issues paper outlining key questions being considered by the Task Force was circulated at the community consultation meetings and comments invited.

A clear and constant message from the community consultation process was issues contributing to suicide and attempted suicide are multiple and interrelated. Many factors, or combinations of factors, may lead to an attempted suicide. These included separation of parents, unemployment, breaking up with a partner, mental illness, drug or alcohol abuse, sexual abuse, overwhelming pressure to achieve, losing a sense of belonging to family and friends, and feeling alienated from society. Suicide is not restricted to any particular group; it knows no age, gender, occupational, cultural or socioeconomic boundaries.

Although the public consultation process provided a great deal of valuable information, the Task Force was concerned to supplement the information from the consultations and submissions for particular groups. Forums and focus groups were held with representatives of:

- Young unemployed people aged 19–24 years.
- Workers with youth.
- People from a non-English speaking background (NESB).
- The Aboriginal community.

A forum was held with representatives of print and electronic media to discuss their role in reporting suicide and potential contribution to prevention strategies. A report was prepared for the Task Force on the role of the media.

The Task Force met with organisations involved in local community initiatives, professionals from a range of service agencies and professional organisations, counselling services of schools, TAFE institutes, universities and non-government welfare organisations, and representatives of key Victorian and Commonwealth government agencies and local government representatives.

Victorian, Australian and international experts were consulted regarding the extent and nature of suicide, prevention and early intervention options, current service provision, education and community development and international best practice.

The Task Force did not consider the issue of Vietnam veterans and suicide, as it was advised the Commonwealth Government was undertaking a detailed investigation. Nor did the Task Force consider assisted suicide and euthanasia. These issues were not within the Task Force's terms of reference.

The widespread community concern about suicide prevention is evident from the many people who contributed to the community consultation process. Over 750 people attended the 15 community consultation sessions conducted by the Task Force, and more than 520 written submissions were received. Task Force members were deeply moved by the many contributions received from individuals who had experienced the death of a loved one by suicide. The Task Force owes a profound debt to these Victorians who so willingly shared their feelings on this most painful of experiences, and its aftermath, in the hope this knowledge would contribute to assisting others in the future.

Similarly, Task Force members are very grateful for the considerable time and effort of peak bodies and other organisations in preparing thoughtful and detailed submissions. The information and recommendations contained in these were of great assistance to the Task Force in its work.

An overview of the public consultation process is detailed in appendix 3. Some of the individuals and organisations who contributed to the work of the Task Force asked for anonymity, or that their material be kept confidential. The Task Force has respected these requests and their contributions, while very useful to the Task Force, are not acknowledged in this document. A list of submitters is provided in appendix 4.

1.2 A UNIFIED VICTORIAN FRAMEWORK

One of the first challenges confronting the Task Force was to establish the scope and breadth of its work. The more the Task Force learned about the extent of risk factors, the more challenging this task became.

Suicide is a complex human behaviour that represents ‘the confluence of psychosocial, biological and environmental vulnerability’ (Baume, 1997). Suicide cannot easily be predicted. While we have known many of the predisposing factors since the end of last century, the particular combinations that lead a given individual to suicide remain unclear. For example, a person who is clinically depressed might complete suicide, but many people who are depressed never attempt suicide. Similarly, drug and alcohol abuse can be contributing factors, but people who abuse drugs or alcohol do not necessarily contemplate killing themselves. The broad range of risk (predisposing) factors and conditions that may lead a person to be vulnerable to an attempt or completing suicide are described in chapter 3 of the report.

The Task Force has recognised its approach to addressing suicide in Victoria must be sufficiently broad in scope to incorporate strategies for primary prevention, early intervention, intervention and postvention (that is, post-suicide support) in a way that empowers individuals and involves the community.

In arriving at a conceptual framework for addressing suicide, the Task Force was conscious it would need to serve many purposes, and account for a range of information such as:

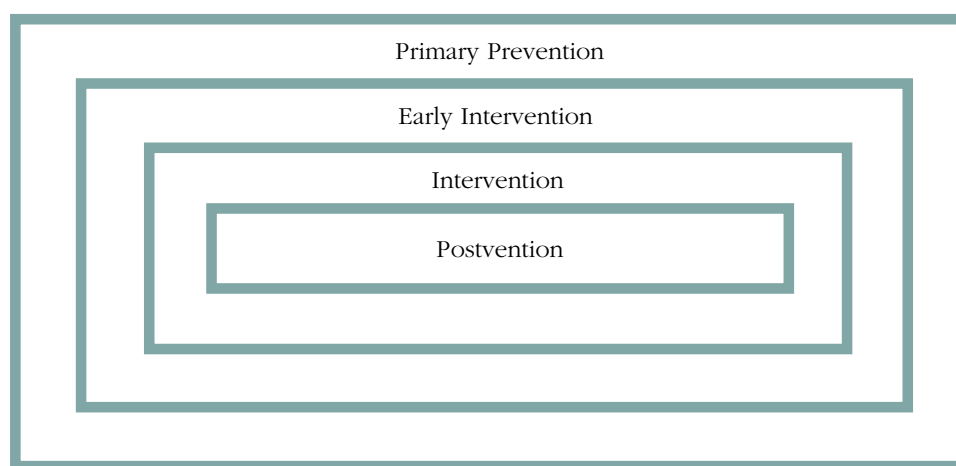
- Risk factors for suicide are extremely wide ranging and may relate to individual, social/environmental and/or health-related vulnerabilities.
- The combination of risk factors that lead an individual to suicide are not predictable.
- Suicide is not a disease. Medical models for responding to suicide are therefore limited, as are existing sociological models addressing human behaviours that fail to acknowledge mental illness is a significant risk factor for suicide.
- Responses to suicide are not the domain of any one service alone. The service system and every element of the wider community needs to work collaboratively to respond to suicide.
- There are major deficiencies in research, evaluation and data collection regarding suicide that need to be addressed.
- Finally, and most significantly, the current service system is fragmented and compartmentalised, and those individuals with combinations of risk factors, which cut across artificial sectoral boundaries, are often at most serious risk of suicide.

These observations led the Task Force toward a conceptual framework within which the existing service system could be unified, and the complex array of factors described above made manageable and definable. The Task Force was mindful that for a framework to be dynamic, it must be flexible and adjustable as new knowledge emerges, and its application must be evaluated for process and outcome.

1.2.1 FRAMEWORK DESCRIPTION

The Task Force believes a comprehensive suicide prevention strategy for Victoria is required. This strategy involves a broad range of activities that can be grouped together in a framework of four interrelated and connected levels. These levels of activity (outlined in diagram 1) reflect the multidimensional nature of the suicide problem as discussed above. The levels the framework encompasses are primary prevention, early intervention, intervention and postvention, which have been derived from the model described by Baume (1996b). The diagram makes clear these levels of activity begin with a broad population-based focus, and become more targeted at each level. It is also clear from the diagram that the levels of activity are complementary and, to a degree, overlap.

DIAGRAM 1: THE VICTORIAN SUICIDE PREVENTION FRAMEWORK



The framework relates to an overall suicide prevention goal the Task Force believes should be adopted for the Victorian community. This is set out below.

1.2.2 GOAL

To reduce the rate of suicide and minimise its incidence and impact through an holistic approach.

The four levels of suicide response forming the suicide prevention framework are discussed below.

1.2 3 PRIMARY PREVENTION

Primary prevention describes population-based rather than individual strategies that may be universally or selectively targeted. Universal strategies are designed for the whole population (for example, media campaigns on mental health).

Prevention approaches account for the coexistence of risk factors such as substance abuse; family discord; sexual, physical and emotional abuse; and mental illness, particularly among young people.

The aim of primary prevention is to raise awareness of what makes a person vulnerable, and develop strategies to reduce vulnerabilities and increase coping skills.

Primary prevention includes:

- Developing better information systems or packages about suicidal behaviours, and disseminating these to the community, services and local government to improve knowledge, understanding and service provision.
- Increasing the knowledge base within the community about factors that lead to suicidal behaviours, such as mental illness (most commonly depression), and developing strategies to tackle them in a more informed and comprehensive way.
- Reducing the social determinants of suicide where possible.
- Designing healthier communities.
- Reducing the access to means.

For example, specific strategies for reducing the access to means, could include:

- Developing measures to reduce access to firearms.
- Redesigning cars to reduce carbon monoxide poisoning.
- Redesigning prison cells to diminish opportunities for death by hanging.
- Changing guidelines to limit access to prescription drugs.

Predicting suicide is difficult. In some cases it is not possible to predict. Greater emphasis on prevention, or population-based approaches is required to complement early intervention, intervention and postvention approaches.

Proposed strategies with a prevention focus have some key features in common. They are intentionally based on a clearly articulated hypothesis about pathways to suicide and the need to block or interrupt these, and promote mental health. By setting in place protective factors, predisposition to suicide can be limited. The literature equates this kind of prevention with health promotion (Felner & Silverman, 1995). Suicide prevention initiatives should include strategies that target the root causes of suicidal behaviours. A range of these strategies is proposed in chapter 5.

The initiatives or programs proposed in the report are aimed at enhancing and promoting the emotional and social health of the community and are unified by a further common feature. They build, rather than damage, *resilience* in the individual. By resilience, we mean a capacity to cope with extreme and stressful life situations. International and national literature provides a solid basis for our knowledge that certain social experiences and arrangements foster resilience in children and young people, and other experiences reduce resilience.

The protective factors in this group of issues may include:

- Minimising family stress (violence, discord and disharmony).
- Strengthening family relationships.
- Ensuring children and adolescents have a relationship with at least one competent, caring adult.
- Promoting a sense of belonging at school or a similar institution.
- Contributing to positive social behaviours and problem-solving skills (self-esteem).
- Fostering a sense of spiritual and communal belonging.

Strengthening these protective factors is not only likely to result in positive outcomes that protect against suicide, but will also promote social health.

1.2.4 EARLY INTERVENTION

Early intervention strategies are targeted at individuals displaying general disorganisation in coping skills, stress reactions, depressive symptoms, and other personal and social vulnerabilities for suicide. It excludes those engaging in suicide attempts or other deliberately self harming or life-threatening behaviours. Early intervention is often described as secondary intervention in public health models. It is focused on groups that are at high risk of self harm.

The goal of early intervention strategies is the effective reduction of the intensity, severity and duration of the risk behaviour. Early intervention, discussed in chapter 6, examines broader predisposing and precipitating factors relating to suicide. It encompasses improvement in detecting, assessing and managing people at risk. Early intervention services are provided by groups such as general practitioners, school counsellors and other counselling services.

Early intervention activities include targeted training of professionals, service providers and the wider community to identify and understand patterns that suggest an individual may be vulnerable to suicidal behaviours. It aims to improve resilience through effective and appropriate support programs and treatment. Individuals who display clusters of predisposing risk factors are a particular focus of early intervention programs. Their multiple needs mean these individuals are especially vulnerable when the service systems are poorly integrated and uncoordinated. This report addresses issues surrounding the need for improved cross-sectoral approaches to early intervention and intervention in chapter 9.

1.2.5 INTERVENTION

Intervention involves providing effective treatment support to those people engaging in suicidal behaviour. Intervention is often referred to as tertiary prevention in a public health model.

Intervention activities include developing, training and embedding effective management practices in emergency departments of hospitals and providing skills for professionals dealing with attempted suicide and intentional self harm. A further goal of intervention programs is to develop best practice models for clinicians who deal with people engaging in suicidal behaviours. The Task Force is conscious that many attempters never present to hospitals or clinical staff, and many of those who do present are released without receiving effective or appropriate psychiatric assessment or treatment. Improving access to mental health and other treatment services for people who attempt suicide presents a major challenge. It also presents a window of opportunity for saving lives.

Strategies include:

- Protocols for ambulance officers, public hospitals and health professionals to facilitate appropriate treatment following suicide attempts.
- Establishment of a specialist mental health professional in emergency departments.
- Rural and regional mental health counselling services for males and Kooris.
- Establishment of therapeutic behaviour intervention programs for young people.
- Appropriate modifications to mental health service delivery.

1.2.6 POSTVENTION

Postvention involves support for the bereaved. Postvention activity recognises those bereaved (the friends, family and peers of a person who has died) may be particularly vulnerable to suicidal behaviours of their own, and may be more likely to develop complicated grief reactions.

Strategies within the category of postvention include:

- Immediate and long-term support for bereaved family and friends.
- Support for witnesses and those with special needs.
- Crisis response plans for schools and other institutions, including work places and prisons, where a suicide may occur.
- Training of professionals to sensitise them to the special needs of those bereaved by suicide.

1.2.7 SUMMARY

This theoretical framework assumes connections between each of these levels of response and supports continuity of care as a unifying principle. For example, it is clear that while postvention deals with the aftermath of a death by suicide, it is also a form of prevention in that it reduces the impact of trauma and serves to prevent further suicides. The key features of the model are that it is comprehensive and rounded, and it acknowledges intersections across levels of intervention. Further, it assumes suicide prevention is a whole-of-community responsibility and will involve partnerships between government, service providers and the community. The approach emphasises the intersectoral nature of prevention in its broadest sense, and has sufficient scope to be inclusive of all levels of participation within the community. Within this framework, it is possible for professionals, non-professionals, carers and other service providers to be involved.

1.3 THE STRUCTURE OF THE REPORT

The Task Force recognises no conceptual framework will completely reflect the reality of suicidal behaviours or the impact on the community and the system that must respond. However, the framework described above has provided a way of organising and managing the diverse issues relating to suicide, and those arising out of the extensive community consultation process.

Having debated the matter at length, the Task Force has decided to structure this report in a way that reflects the above conceptual framework and is aware this may be presenting a new way of looking at the existing service system. The framework may challenge some professionals to reconsider their place in the system, their relationship to other professionals, and those they serve.

This is a conscious and deliberate decision based on a vision that it is possible for people to come together around the goal of suicide prevention; to forge new partnerships, to adapt, to change, and to modify their core business in ways that may foster cooperation and dismantle existing barriers. We have adopted a conceptual framework we hope will promote a more holistic approach to meeting the needs of Victorians.

The structure of the report reflects the goal and objectives outlined at the outset of this chapter. Chapter 2 of the report sets out the incidence of suicide. Chapter 3 describes the broad range of risk factors that heighten vulnerability to suicide. Together, these two chapters address the nature and extent of suicide in Victoria. Chapter 4 describes responses to suicide within the existing service system. Chapters 5, 6, 7 and 8 draw on the community and professional input to the Task Force to analyse strengths and deficiencies in current responses, and to propose strategies for improvement.

Chapter 5 addresses responses to enhance broad population-focused primary prevention factors. Chapter 6 outlines early intervention approaches to assist individuals who may be vulnerable to suicide. Chapter 7 provides suggestions on how to improve intervention for those people who have current suicidal behaviours. Chapter 8 addresses

postvention approaches to ensure that those affected by suicide deaths receive the support they need. Finally, chapter 9 considers issues relating to the successful implementation of Victoria's suicide prevention strategy, including the necessity for services to be integrated and coordinated.

During the course of its investigations, the Task Force heard many examples of good practice. The examples included in chapters 5 to 9 have been selected to illustrate particular issues. There are many other examples of initiatives worthy of support that it has not been possible to include in this report.

In compiling this report, the Task Force has sought to reflect the views expressed in the written submissions and by the people who contributed to the community consultations held across Victoria. The comments in the text have been selected to represent particular themes the Task Force heard many times. The quotes from the *Community Consultations* used in the text include material drawn from a wide range of individual consultations in rural and metropolitan Victoria. Each one is a quote from an individual who attended the consultations.

A number of case studies have been used in the report to highlight the complex range of factors involved in each death by suicide or attempted suicide. Some of these case studies have been 'constructed' from submissions received by the Task Force because they exemplify recurring themes from evidence presented to it. Where case studies are based on specific individual submissions, the written permission of the individuals concerned has been obtained and every effort made to delete any identifying material.

In framing its recommendations, the Task Force believes strategies to reduce the incidence of suicide must involve the whole community. Although government has a major role to play, it needs wider community support. It requires the commitment of individuals, families, churches, community, service and voluntary organisations, the media, the business community, local councils and sports clubs. The Task Force believes with such cooperation, a life-affirming culture within the Victorian community can be fostered.

