



EXECUTIVE SUMMARY

INTRODUCTION AND CONTEXT

Each suicide is a tragic and unique event. Death by suicide reflects an intensely personal set of circumstances for the individual, their family and friends, and it sometimes affects whole communities. The tragic reality is that one Victorian will end their life by suicide every 16 hours of every day of every week.

In Australia, suicide is now the leading cause of death due to injury ahead of motor vehicle accidents and homicide. For young people, deaths by suicide have tripled since the 1960s. It is estimated that for each week in 1995, an average of two young people in Victoria died by suicide. Rises in suicide rates among young people, especially young men, is a growing international trend.

The Suicide Prevention Task Force was charged with undertaking an intensive public investigation into the nature and extent of suicide, particularly youth suicide, in Victoria. The terms of reference and the members of the Task Force are listed in appendices 1 and 2 of the full report. In developing its recommendations, 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 that provide help and support.

The overwhelming concern of Victorians about this issue was evident from the fact the Task Force received over 520 written submissions and views from many of the 750 people who attended the 15 public consultations held in regional and metropolitan Victoria. In addition, the Task Force had discussions with many experts, national and international, and with groups of people and specialist organisations. These are listed in appendices 4, 5 and 6 of the full report.

The Task Force has produced a detailed report which it believes:

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

This summary provides a brief outline of the key information and major themes discussed in the report. The recommendations of the Task Force are included in this document; however, to gain a comprehensive understanding of the background to and purpose of these recommendations, the full report will need to be read. It is the view of the Task Force that, although government has a major role to play, implementation needs wider community support.

THE DIMENSIONS OF THE PROBLEM

During the course of its inquiry, the Task Force became aware of the varying levels of community understanding about the incidence of suicide. The analysis contained in chapter 2 of the report challenges some of the common myths concerning suicide, and confirms a number of significant facts about the nature and extent of the problem.

METHODS OF SUICIDE

One of the factors that helps explain male/female differences in rates of death by suicide is the use of more violent and more lethal suicide methods by men. The methods of suicide vary over time according to gender and locality. The most common methods are hanging, carbon monoxide poisoning, firearms and ingestion of substances.

URBAN AND RURAL DIFFERENCES

Suicide rates, especially for young adult males, are particularly high in rural areas. Small, isolated country towns are particularly vulnerable to high suicide rates. However, pockets of equally high suicide rates also occur in certain metropolitan areas.

SUICIDE ATTEMPTS

Attempted suicides are more difficult to study because there are no generally accepted reporting procedures nor well-accepted definitions. The incidence of suicide attempts has been found in suicide studies to vary significantly by gender, and there are estimates of between 30 and 50 suicide attempts for every male suicide, and between 150 and 300 attempts for every female suicide. These estimates indicate many more attempt suicide than die from suicide each year in Victoria.

MAJOR RISK FACTORS

Issues contributing to death by suicide and attempted suicide are multiple and interrelated. Many factors, or combinations of factors, may lead to a suicide attempt (see chapter 3 of the report).

Suicide is not restricted to any particular group and knows no age, gender, occupational, cultural or socioeconomic boundaries. From all of the evidence presented during the inquiry, the Task Force has concluded there is no one single factor that may lead an individual to suicide. Suicide is a highly complex act and it cannot easily be predicted.

The factors that may lead an individual to be vulnerable to suicide appear to be extremely wide ranging. Biological, social and psychological factors have all been identified as affecting suicidal behaviour.

PRIOR ATTEMPTS AND DELIBERATE SELF HARM

A past history of attempted suicide has been shown to be a strong predictor of future death by suicide. There is evidence to show that people engaging in severe self harm are also at higher risk of suicide.

MENTAL ILLNESS

People who have been diagnosed with a psychiatric disorder face a statistically higher risk of suicide than the general population. Considerable evidence links suicide and suicide attempts with depression, schizophrenia, bipolar disorder, conduct and personality disorders.

Information provided by the Depression Awareness Campaign shows that in Australia, one in four women and one in six men will experience depression at some time in their life, yet only 20 per cent to 26 per cent of depressed people receive treatment.

Between 60 per cent and 90 per cent of young people who attempt suicide are depressed. Many young people (about 40 per cent in any six-month period) suffer prolonged periods of sadness or unhappiness that may affect their ability to cope.

Most young people with depression receive no treatment because much of it goes unrecognised and is mistakenly assumed to be normal adolescent 'acting out' behaviour.

A 1994 study of psychiatric disorder and risk factors for elderly persons over 65 who had attempted suicide found that 41 per cent had major depression or schizophrenia, 30 per cent had minor depression, anxiety or personality disorder, and 29 per cent suffered from dementia or delirium.

DRUG AND ALCOHOL ABUSE

Many studies have found higher rates of suicide among alcoholics and drug abusers. Alcohol and substance abuse by adolescents often immediately precedes suicidal behaviour. Alcohol and substance abuse is also linked to depression.

SOCIAL FACTORS

A number of reports over the past three or four decades have pointed to the increase in adverse social conditions such as unemployment, economic hardship, and family discord and conflict. With the rise in prevalence of such social issues in the community, it may be that the growing rates of depression and suicidal behaviours reflect, in part, the increasing presence of these social stressors.

Other social factors that may contribute to a risk of suicide include poor social relationships and feelings of hopelessness, homelessness, relationship breakdown or the recent loss of a spouse or partner, family discord, and sexual abuse.

The broad range of risk (predisposing) factors are described in greater detail in chapter 3 of the report.

A FRAMEWORK FOR SUICIDE PREVENTION

The reasons for suicide are so complex that the Task Force has taken a very broad view of the responses required to prevent it, particularly among young people.

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 approaches:

- Primary prevention.
- Early intervention.

- Intervention.
- Postvention.

Strategies that strengthen the capacity of individuals to cope with life's stresses and reduce potential vulnerability to suicide are needed. Schools, families, the media, business and community organisations all have a role to play in fostering the development of a sense of purpose, self-respect and confidence among young people, and promoting a sense of belonging in their communities for all Victorians. (Primary Prevention)

Services that support people who may have particular social, health or emotional problems that make them more vulnerable to suicidal behaviour need to be responsive and provide continuity of care. (Early Intervention)

Accessible and immediate crisis support services must be available to individuals who are exhibiting suicidal behaviours. (Intervention)

Immediate and ongoing post-suicide supports are required for the bereaved families and friends, witnesses to suicide, the immediate community and first responders and professionals. (Postvention)

PRIMARY PREVENTION

Prevention is far more effective than intervention. We need to build on and not dismantle our social support structures. Self-esteem, stress management, managing emotions and practical communication skills should be part of preparation-for-life skills, not just available in crisis counselling situations. (Community consultation)

Primary prevention (see chapter 5 of the report) describes population-based rather than individual strategies.

Primary prevention aims to raise awareness of what makes a person vulnerable to suicidal behaviour, to develop strategies to reduce vulnerabilities, and to increase protective factors and resilience.

STRENGTHENING FAMILIES

Strengthening families was identified as an important factor in supporting the development of young people. Many parents seek knowledge on how to parent more effectively, and how to improve their relationships with their children.

Support should be provided to families to enhance the physical and emotional health of their children, and to prevent the development of dysfunctional relationships.

CREATING POSITIVE RELATIONSHIPS

Positive relationships outside the family are also significant, and may occur in educational institutions, places of employment or community organisations. A number of submissions highlighted the importance of initiatives that create the opportunity for young people to receive the consistent support of an older mentor, particularly when such support is not available at home.

PROMOTING THE ROLE OF EDUCATION

Young people spend more time in school than in most other structured environments outside the home. They often have their most consistent and extensive contact with trained professionals in school. Schools are well placed to assist students in developing self-esteem and self-confidence, and to identify and support students at risk.

The need for schools to adopt an holistic approach to a young person's needs that balances responsibilities for pastoral care and student academic progress was a constant theme of the public consultation process.

STRENGTHENING LOCAL COMMUNITIES

Task Force members were concerned by the apparent lack of knowledge about suicide prevention in the general community; however, they heard of many instances where it had been addressed by actions taken by the local community to improve links between services and strengthen local support.

CREATING POSITIVE SOCIAL BEHAVIOURS AND PROBLEM SOLVING SKILLS

Low self-esteem, especially in young people, is a common feature of suicide cases made known to the Task Force. It heard evidence of the positive benefit of community-based programs that develop problem-solving skills and/or provide adventure experiences for young people.

PROMOTING HELP SEEKING

The Task Force heard that even when information and services were available, certain groups in the community were much less likely to access services in times of crisis. This was true of men, particularly young men. For example, calls by males generally account for only 20 per cent of calls to telephone crisis services. Consequently there is a need for strategies which encourage those who need help to seek it.

INCREASING PUBLIC AWARENESS AND ACCESS TO INFORMATION

There appears to be a lack of awareness in the community about the factors associated with suicide and warning signs. The Task Force believes one of the key areas of prevention is developing a community education strategy that provides accurate information about mental illness and mental health issues, and promotes greater understanding of the nature of depression and other psychiatric disorders.

PROFESSIONAL TRAINING

The Task Force was informed that additional training of many professionals and others who work with young people would assist suicide prevention. Such professional education and training was required at both pre-service and in-service.

RESEARCH, EVALUATION AND DATA COLLECTION

The Task Force is convinced of the need to underpin suicide prevention strategies with research, evaluation and data collection. There is considerable scope for improving the knowledge base on which to develop appropriate initiatives in suicide prevention, and to improve understanding of what works and does not work when it comes to preventing people taking their own lives.

ACCESS TO MEANS

The majority of suicide deaths result from hanging, firearms, carbon monoxide poisoning and overdoses. Many attempts involve use of prescription pills and other poisoning substances. Therefore, reducing access to means is a critical prevention strategy.

THE MEDIA

Submissions to the Task Force expressed concern about the inappropriate reporting of suicide, self-harming and risk-taking behaviours and suggested the need for establishing a media code of practice.

EARLY INTERVENTION

Very many of these young people had already exhibited strong symptoms early in their teens. They could easily have been picked up earlier and perhaps helped long before it came to a crisis time. In some cases they were picked up, but they were not helped and were passed on from one supposed expert to another. (Community consultation)

Early intervention (see chapter 6 of the report) examines broader predisposing and precipitating factors relating to suicide.

Services for those identified as being at risk of suicide include education, welfare, and medical and crisis telephone assistance. Many submissions focused on the difficulties experienced by people seeking assistance and support in times of stress. The Task Force heard from a number of agencies seeking to reduce the intensity, severity and duration of risk for those who displayed clusters of predisposing or risk factors. A combination of services seem to be necessary in most cases.

PRIMARY AND SECONDARY SCHOOLS AND POST-SECONDARY

EDUCATION INSTITUTIONS

There was widespread community support for strengthening welfare practices in schools, and apparent consensus that the school is an appropriate site to target service delivery for students who are homeless, abused, depressed and lacking in social skills and self-esteem. Submissions to the Task Force supported the view that development of coordinated health, educational and welfare services could be further strengthened through networks established between the Department of Education and the Department of Human Services.

JUVENILE JUSTICE, CHILD PROTECTION AND CORRECTIONS

Young people on court orders often have entrenched and multiple behavioural and emotional difficulties such as substance abuse, aggression, psychological disorders and exclusion from school. An essential element in early intervention for such young people is systematic case management, particularly for those young people who are in transition from care to independence.

SEXUAL ASSAULT AND RELATED GENDER-SPECIFIC SERVICES

The Task Force received numerous individual submissions on the impact sexual assault has on victims that often manifests much later in life and gives rise to risk of self harm and suicide.

The Task Force also heard that men also respond better to gender-specific services.

DRUG AND ALCOHOL SERVICES

The Task Force received considerable input on the important role of drug and alcohol services in contributing to suicide prevention.

Drug and alcohol workers need to be skilled in assessing suicide risk factors, and to be aware of the need to support those who are vulnerable and/or depressed. Such support must include mental health and drug and alcohol services.

GENERAL PRACTITIONERS

General practitioners can offer accessibility, continuity of care and comprehensive health care. In addition, they may provide culturally sensitive services, particularly when they have bilingual skills or close links with ethnic communities.

A number of GPs expressed concern about inadequate support from the mental health system, lack of available inpatient beds, and poor remuneration under Medicare for long consultations, attendance at case meetings and networking with other services.

Young people have particular problems with access to GPs, and disadvantaged young people make even less use of mainstream health services. GPs need to develop the expertise and confidence to engage young people more effectively. Better links between GPs and other sources of assistance (such as counselling, youth support services, and mental health services) are necessary in many cases.

CRISIS TELEPHONE SERVICES AND AFTER HOURS SUPPORT

Many Victorians expressed concern to the Task Force about the lack of 24-hour access for people requiring support, and information in times of crisis. If Victoria is to reduce the numbers of deaths by suicide, services need to be made available when required. This is often outside normal business hours.

People with active suicidal behaviour and their families need immediate and responsive support. When such people contact telephone counselling services, they often need face-to-face counselling and treatment.

INTERVENTION

With sick or difficult teenage children, parents often have to rely on other people to assist and guide them. In seeking help from public medical areas we expect to receive professional direction, but are often let down. (Community consultation)

FIRST RESPONDERS

Intervention support and treatment services are critically involved in dealing with suicide prevention at the point of crisis, and act as 'first responders' to suicide threat. Police and ambulance services are prominent among the first responders.

Improving crisis response, support and treatment, especially from first responders is critical for people with suicidal behaviours.

EMERGENCY DEPARTMENTS

The consultation process identified a number of inadequacies of emergency departments in treating individuals who have attempted suicide.

A common complaint was emergency departments rarely provided psychiatric assessment for suicide attempters, and they were frequently discharged without follow-up being arranged. Families often received little, if any, information

from the hospital about how to manage the attempter or where to go for further help.

The Task Force believes a number of measures need to be implemented to provide suicide attempters with assessment and appropriate care, referral and follow-up.

MENTAL HEALTH SERVICES

Although Victoria has been a leader in providing mental health services, many submissions expressed the view that mental health services are inadequate, unresponsive or inaccessible when dealing with suicidal people.

There appears to be a significant service gap for people who do not meet current criteria for assistance from the mental health system yet are not adequately assessed or treated by GPs for their psychiatric disorders. Therefore, the Task Force has considered the need for additional services for these people.

The Task Force received evidence regarding suicides of persons who had previously been treated in the Victorian public mental health sector. The suicide rate was higher for those patients where there had been no community follow-up after discharge from inpatient care. Therefore, there is a need for active follow-up of patients discharged from inpatient care who are known to be at higher risk of suicide. Prior to discharge from hospital, a comprehensive caseplan needs to be developed to assist smooth re-entry into the community.

ACCESS TO INPATIENT SERVICES

Several submissions highlighted the difficulty of access to adolescent inpatient beds, particularly in rural regions. Often the shortage resulted in the inappropriate placement of young people in adult inpatient facilities that generally have not been responsive to the developmental needs of adolescents.

SERVICES IN RURAL AREAS

The Task Force believes there is a need for greater access to counselling services for communities in rural and remote areas, particularly in areas with significant Aboriginal populations.

PROVISION OF MENTAL HEALTH SERVICES FOR YOUNG PEOPLE

Currently, young people move from being the responsibility of Child and Adolescent Mental Health Services to Adult Mental Health Services at around the age of 18, or when they leave their parental home. This can lead to a break in the continuity of care.

There is a need for an improved approach to treating young people that would include a greater emphasis on the importance of the family and non-medical systems.

Evidence was provided to the Task Force that patient confidentiality is often used as the rationale for lack of comprehensive care. The Task Force believes professionals should work cooperatively with families to ensure care is effective and there is continuity of care.

SERVICES FOR PEOPLE WITH PERSONALITY DISORDERS

Concern was expressed during the consultations about the difficulties experienced in gaining access to, or adequate treatment from, mental health services for individuals diagnosed as having personality disorders. Evidence presented to the Task Force suggests that, when confronted with an individual with a personality disorder, the service response has often been crisis driven and ad hoc.

CRISIS INTERVENTION

The major criticism of mental health services at the public consultations was regarding the limitations of services provided by the Crisis Assessment and Treatment (CAT) teams.

Submissions received suggested CAT services are mainly focused on inpatient 'gate-keeping' and people presenting with psychosis. Criticisms of the service included lack of sensitivity and responsiveness to adolescent risk-taking behaviours; failure to provide timely, after-hours crisis assessment to young people; leaving a 'crisis' without taking any further action; or failing to make an appropriate referral to another agency.

Therefore, the Task Force is of the view that CAT teams must be required to make alternative referrals if a client is assessed as not needing hospital treatment, and to ensure that follow-up mental health services are provided.

RESIDENTIAL AND RESPITE CARE

The Task Force heard evidence of the desperation experienced by members of the community in being unable to find a place of safety or access to an appropriate professional for family members who appeared to be at imminent risk of suicide. Many people exiting hospital emergency departments following suicide attempts remained in a precarious emotional state and in danger of further self harm. Homeless people exiting mental health services with only sketchy discharge plans often have nowhere to go. The Task Force believes that, for some young people in crisis, there is a need for residential support on a short- to medium-term basis.

POSTVENTION

Where suicide is an issue, families and carers have expressed the need for greater support. This involves the need for compassion, understanding, support and counselling to family members and the carers of people who have attempted or completed suicide. Grief counselling services are thus considered a priority for families and carers. (Community consultation)

Postvention activity (see chapter 8 of the report) recognises that 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.

Postvention strategies include:

- Providing immediate and long-term support for bereaved family and friends.
- Supporting first responders, witnesses and those with special needs.
- Ensuring that crisis response plans are in place in schools and other institutions (including work places and prisons) where a suicide may occur.
- Training professionals to understand the special needs of those bereaved by suicide.

IMPLEMENTING VICTORIA'S SUICIDE PREVENTION STRATEGY

...An integrated response from the key players involved—the at-risk person, family, psychiatrist/psychologist, general practitioner...police...telephone counselling service etc.—could jointly and effectively provide support, develop a plan to try to prevent attempts and work to restore hope. (Written submission)

The Task Force believes it is essential that an effective implementation strategy be developed that takes account of the need for coordinated and integrated services to support and treat individuals at risk of suicide (see chapter 9 of the report).

COMMONWEALTH AND STATE COORDINATION

The Task Force believes the Commonwealth Government should take the lead role in facilitating collaboration between the Commonwealth and the States/Territories in developing a national approach to suicide prevention.

STATEWIDE POLICY COORDINATION AND SERVICE INTEGRATION

Despite its many strengths, the service system that relates to suicide prevention in Victoria operates with a lack of coordination and integration.

The Task Force identified a number of improvements required in the current service system, such as the need for some services in each region to be available outside of normal business hours to make them more effective in preventing suicide. Better coordination of policy and service delivery at the State level will be necessary to bring about these improvements. The coordination mechanisms are described in chapter 9 of the report.

LOCAL GOVERNMENT

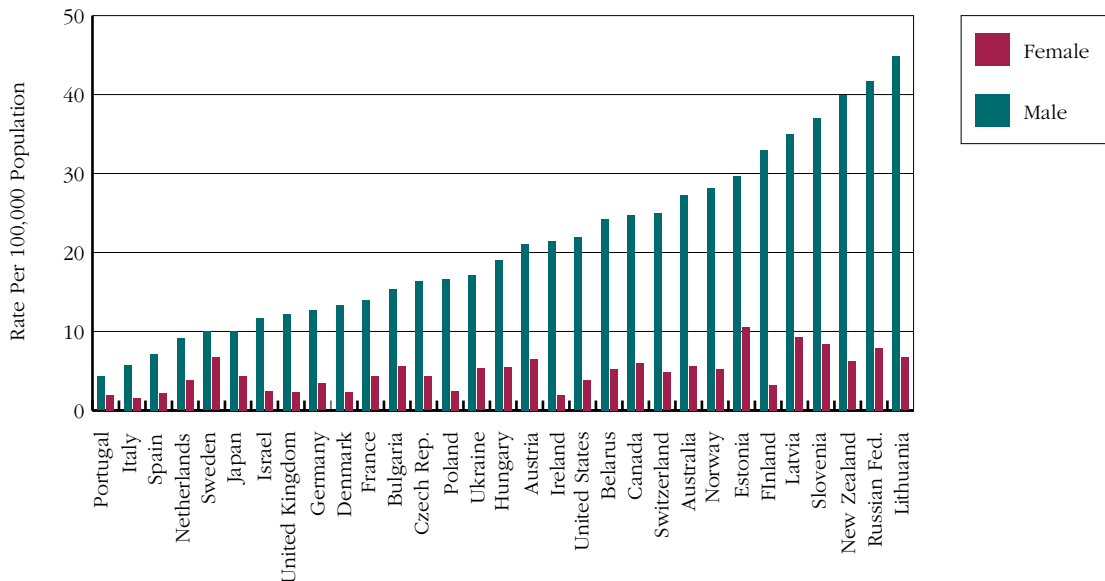
Local government has a vital role to play in supporting local communities. Its role should be to coordinate existing services at the local level and ensure the best mix of services for suicide prevention is available and well targeted.

REGIONAL/LOCAL AREA SERVICE INTEGRATION

To be effective, many of the early intervention and intervention responses to suicidal behaviour described in the report require regional or local cooperation and collaboration. Multisectoral models of service provision that are currently operating provide a basis upon which to build. Examples of these are described in chapter 9 of the report.

KEY FACTS

DEATHS BY SUICIDE—INTERNATIONAL DATA 1991–93 FOR PEOPLE AGED 15–24 YEARS (RATES PER 100,000)
(REPORT FIGURE 2.1)

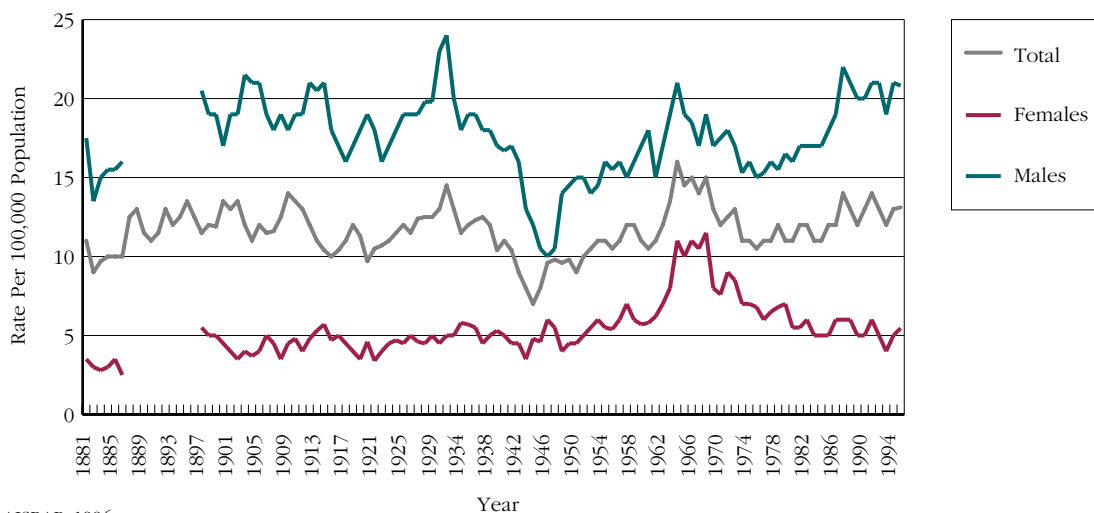


Source: Australian Institute for Suicide Research and Prevention (AISRAP, 1996).

KEY ISSUES

- Australia has one of the higher rates of suicide among young people aged 15–24 years in developed countries.
- Death by suicide accounted for around 3 per cent of all deaths in Australia in 1995. For those aged 15–24 years, death by suicide represents about 20 per cent of all deaths: about 25 per cent of all deaths for males, and 17 per cent for all females of the same age group.

DEATH BY SUICIDE IN AUSTRALIA: MALE, FEMALE AND TOTAL, ALL AGES, 1881–1995 (RATES PER 100,000)
(REPORT FIGURE 2.2)



Source: AISRAP, 1996

KEY ISSUES

- While overall rates of suicide have fluctuated at times in Australia, they have essentially remained the same over the past 100 years. Rates have been significantly higher for males compared with females, which partly reflects methods of suicide.
- Since the 1960s, there has been a dramatic rise in suicide rates among young males, especially those aged 20–24 years. The increase reflects a worldwide trend.

RATES OF SUICIDE FOR EACH STATE AND TERRITORY BY GENDER: 15–24 YEAR OLDS, 1995 (REPORT FIGURE 2.5)

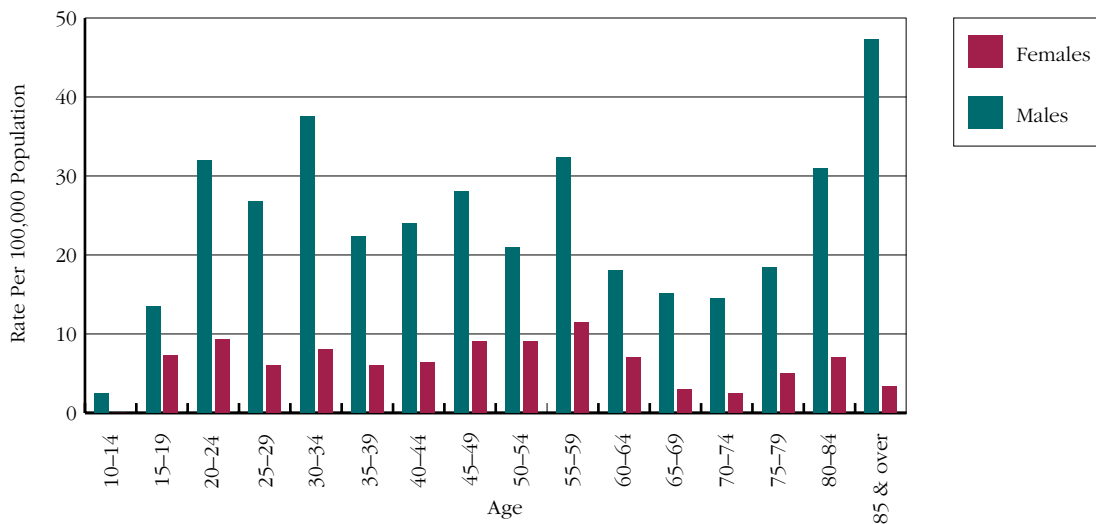


Source: Australian Institute for Suicide Research and Prevention 1996

KEY ISSUES

- Victoria’s rate of suicide for all age groups was 12.4 per 100,000 population in 1995. This was just below that for Australia at 13 deaths per 100,000.
- Victoria’s rate of youth suicide in 1995 was among the lowest of all States and Territories for males, but among the highest for females.
- When taken as a 30-year average since 1964, Victoria, with New South Wales, has shown the lowest recorded average rate of youth suicide among all States and Territories.

RATES OF SUICIDE BY AGE AND GENDER, VICTORIA, 1995 (REPORT FIGURE 2.11)

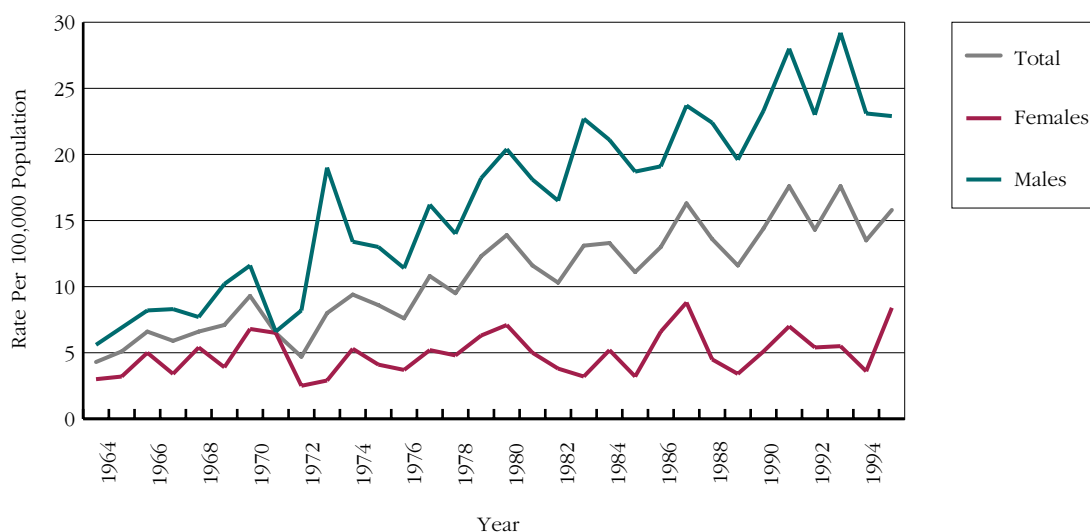


Source: Australian Bureau of Statistics (Unpublished data, 1995)

KEY ISSUES

- Suicide transcends all age groups. In terms of numbers, males aged 20–24 and 30–34 constitute the highest group. In terms of rates per 100,000 population, males aged 85 plus years are highest, although numerically this group is small.
- Deaths by suicide are highest for males across all age groups. Suicide numbers begin to increase after early adolescence.
- For every death by suicide in Victoria in 1995, the estimated loss of potential human life and endeavour to the community was 36.7 years. This compares with an estimated 41 years lost from deaths through motor vehicle traffic accidents.
- The number of people bereaved by suicide in Victoria is estimated at between 5000 and 6000 based on Victoria’s 566 deaths by suicide in 1995.

RATES OF YOUTH (15–24) SUICIDES BY GENDER, VICTORIA, 1964–95 (REPORT FIGURE 2.12)

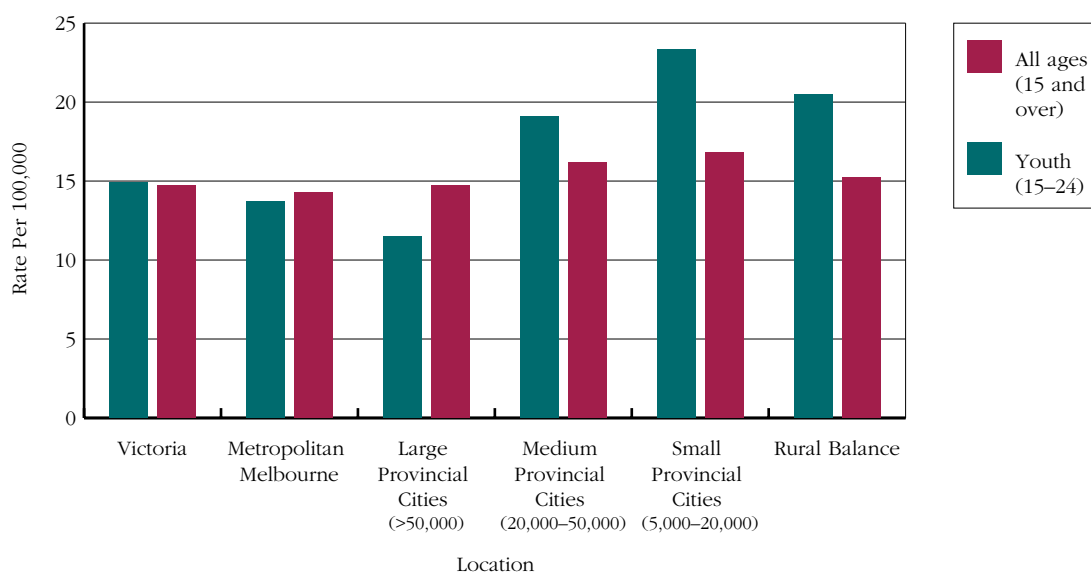


Source: AISRAP, 1996

KEY ISSUES

- Suicide rates for males have increased dramatically in Victoria (from 5.6 per 100,000 in 1964 to 22.9 per 100,000 in 1995). Female rates have more than doubled (from 3.0 per 100,000 in 1964 to 8.4 per 100,000 in 1995). This is in contrast to suicide rates for middle aged (45–54) and older aged (65 plus) people that have generally fallen over the 30-year period.
- While deaths by suicide are most common among males, suicide attempts are most common among women, especially young women. Self-inflicted injuries have shown a statistically significant increase in Victoria over the period 1987–96 for which data is available.

YOUTH (15–24) VS. ALL-AGE SUICIDE RATES BY LOCATION, VICTORIA, 1990–95 (REPORT FIGURE 2.18)



Source: Australian Bureau of Statistics (Unpublished data, 1990–1995)

KEY ISSUES

- Suicide rates are higher in rural Victoria than Victoria as a whole and metropolitan Melbourne for all age groups.
- Rates are also known to be high in inner Melbourne for youth aged 15–24 and all-age suicides.



RECOMMENDATIONS

The recommendations are set out here for convenience. It is important to consider the reasons for, and the background to, these recommendations to gain a full understanding of their objectives. This will only be done by reading the chapters that contain them. Reading the report in its entirety will assist a full appreciation of the purpose of the recommendations.

CHAPTER 5: PRIMARY PREVENTION

5.1 The Victorian Government support the Department of Human Services to expand and enhance opportunities for parent education, including a particular focus on step-parenting and father-son relationships. Programs should support parents to communicate with adolescents. (See section 5.1)

5.2 The Minister for Health support the Victorian Foundation for Survivors of Torture and raise with the Commonwealth the need to expand post-traumatic stress counselling services with particular focus on child and adolescent refugees and people who came to Australia as part of the unaccompanied minors program. (See section 5.1)

5.3 The Victorian Government support the Department of Human Services to develop a training program with the Aboriginal community to provide them with the skills to deliver counselling services through their extended family networks. (See section 5.1)

5.4 The Victorian Employers Federation, Victorian Employers Chamber of Commerce and Industry and other employer organisations encourage employers to adopt mentor schemes to provide an orientation program and to promote confidence and self-worth in young people entering the work force. (See section 5.2)

5.5 The Victorian Government and an employer organisation pilot the New Zealand model of employees providing support to primary school age children. (See section 5.2)

5.6 The Victorian Government support the Department of Education to develop and implement a policy that specifies minimum standards of student welfare provision within government schools. (See section 5.3)

5.7 The Minister for Education consider including peer support programs within the overall minimum standards of student welfare. (See section 5.3)

5.8 The Minister for Education review the school charter and school review guidelines to enable the role of schools in promoting the personal welfare of individual students and in promoting connectedness to school to be identified and measured as part of the overall accountability process. (See section 5.3)

5.9 The Minister for Education review the student attendance guidelines to ensure that follow up of absences, without a satisfactory explanation, occurs within 48 hours. (See section 5.3)

5.10 The Ministers for Education, Health and Youth & Community Services initiate discussions between local service providers, such as general practitioners, youth workers, community health centre nurses, to develop models for providing outreach services to schools. (See section 5.3)

5.11 The Minister for Education and Minister for Health examine the outcomes of the Gatehouse Project to determine its applicability to the whole school system. (See section 5.3)

5.12 The Minister for Tertiary Education discuss with the Councils of Universities and Technical and Further Education Institutes the importance of their social welfare policy and structures in promoting student wellbeing and preventing suicide, including issues such as the need for effective induction programs, especially for students from rural areas, for peer support activities and accessible counselling programs for students. (See section 5.3)

5.13 The Victorian Government explore financial and other incentives to encourage health and other professionals relevant to suicide prevention to locate in rural areas. (See section 5.4)

5.14 The Victorian Government support Rumbalara Football and Netball Club to implement their Healthy Lifestyles program aimed at strengthening the community, and evaluate the program to determine its broader applicability. (See section 5.4)

5.15 The Victorian Government support the Department of Education to:

- **Expand the Victorian Youth Development Program to all schools.**
- **Develop and implement an alternative Student Achievement Program for students in Year 6 and Year 7 that includes wilderness adventure and sports-based options among the program's activities. (See section 5.5.1)**
- **Establish a special fund to assist children from low-income households to participate in the Victorian Youth Development Program and Student Achievement Program.**

5.16 The Victorian Government, VicHealth and the business community consider funding recreation, arts and sports-based self-esteem building programs. (See section 5.5.1)

5.17 The Victorian Government raise with the Commonwealth Government the elimination of the six-month gap before case management applies for unemployed young people exiting the education system, enabling those young people to participate in relevant training and other assistance at the time when their motivation and self-esteem are at their highest. (See section 5.5.1)

5.18 The Minister for Health and Minister for Youth and Community Services commission a project to develop strategies for encouraging help seeking by males and to improve their access to services. (See section 5.5.2)

5.19 The Victorian Government support a long-term, broad public awareness media campaign using high-profile role models to promote positive community mental health, and to encourage men to access services. Particular attention should be paid to rural areas. (See section 5.6)

5.20 The Victorian Government support increased access to suicide prevention information through a project to make statewide and local information available on-line through the Internet. (See section 5.6)

5.21 The Victorian Government support local councils, through small grants, to develop interactive computer-based and hard copy suicide prevention resource directories, booklets, brochures and videos that identify all the services available in their municipalities relevant to suicide prevention, and make that information widely available and accessible to all local services, the media and others in the community. (See section 5.6)

5.22 The Minister for Tertiary Education in association with professional bodies request tertiary institutions to review course structure and content of tertiary courses for professionals (including teachers, social workers, health workers and medical practitioners) to place greater emphasis on understanding adolescent behaviour and family dynamics, suicide risk assessment and early warning signs, identification of depression, referral strategies, and coping with grief and bereavement. (See section 5.7)

5.23 The Victorian Government encourage all government and funded services to provide in-service training and professional development opportunities for teachers, youth workers, general practitioners and other allied health workers. These programs should include training modules for communication skills, risk assessment, identification of depression, referral strategies and ways of coping with grief and bereavement. (See section 5.7)

5.24 The Victorian Government, as a matter of urgency, raise with the Commonwealth Government and the vehicle manufacturing industry the need for changes in new vehicle design to reduce the incidence of suicide through carbon monoxide poisoning. Such changes to include:

- **Introduction of alarms and carbon monoxide detectors in new vehicles that will disable the engine if the amount of carbon monoxide in the vehicle exceeds a designated safety level.**
- **Introduction of 'exhaust baffles' that place an obstruction in exhaust pipes to impede the insertion of hoses.**
- **Installation of catalytic converters in new vehicles that have been tested at idling speed to minimise the emission of carbon monoxide. (See section 5.8)**

5.25 The Victorian Government request the Victorian Farmers Federation to include firearms safety information (in particular, safe storage of firearms and ammunition) as a core element of the Victorian Farmers Federation farm safety program. (See section 5.8)

5.26 The Victorian Government seek the cooperation of community organisations, particularly in country areas (such as Rotary, Apex and shooters clubs) to provide information to their members on the safe storage and handling of firearms and ammunition as part of a concerted firearms safety campaign. (See section 5.8)

5.27 The Minister for Transport request the Public Transport Authority to examine the incidence of suicide on train lines with a view to establishing physical barriers that may prevent easy access for persons at risk of suicidal behaviour in high-risk locations. (See section 5.8)

5.28 The Victorian Minister for Health request the Commonwealth Minister for Health to establish a small expert working party to investigate a number of strategies that could reduce the incidence of suicide, including:

- Modification of paracetamol by addition of methionine.
- Restriction of the sale of paracetamol to pharmacies, and only where the name and address of the purchaser is registered.
- Methods that encourage the prescription of newer antidepressant drugs that are less toxic than tricyclic antidepressant drugs.
- The impact of recent Commonwealth changes to pharmaceutical benefits to ensure that such changes do not result in continued prescription of tricyclic antidepressants due to cost pressures. (See section 5.8)

5.29 The print and electronic media adopt and actively implement a code of practice for suicide reporting. (See section 5.9)

5.30 The Minister for Tertiary Education request relevant post-secondary institutions to include issues relating to suicide and reporting of suicide in tertiary media and journalism courses. (See section 5.9)

5.31 The Minister for Health develop and maintain an information kit that provides details of experts who could make authoritative comments or provide guidance and advice on issues related to suicide. This information could be available on the Internet, on disk or as hard copy. (See section 5.9)

5.32 The Victorian Government facilitate the establishment of a consortium of media organisations and tertiary institutions with relevant expertise to develop a case study kit that presents examples of best practice reporting. This would aim to establish a best practice standard in journalism in suicide prevention reporting. Continuing education for journalists through circulating such kits would assist in raising the level of awareness and knowledge. The kits could be distributed to journalism and media studies courses and incorporate a training video detailing examples of positive and irresponsible reporting. (See section 5.9)

5.33 The Victorian Government encourage the country media (local print, radio and television) to participate in a community education/information campaign for rural Victoria designed to increase information about, and access to, services for people with depression. (See section 5.9)

5.34 The Victorian Government encourage the print media to consider developing a youth page to provide information about activities and services for young people, and to promote positive images of young people. (See section 5.9)

5.35 The Minister for Multimedia initiate research into strategies for the use of the Internet in suicide prevention. (See section 5.9)

5.36 The Victorian Minister for Health encourage the Australian Council of Health and Community Services Ministers to develop a national approach to suicide prevention research and data collection. (See section 5.10.1)

5.37 The Victorian Minister for Health encourage the Commonwealth Department of Family Services to coordinate national suicide prevention efforts with those taken by Victoria and other States/Territories. (See section 5.10.1)

5.38 The Victorian Government support the Office of the Victorian Coroner to increase its capacity to collect and analyse data on completed suicides, including information in relation to suicide and non-English speaking and Koori communities, and collaborate in key areas of research with other research bodies. (See section 5.10.1) Overall, a program of ongoing, structured research should be undertaken into the factors that operate to cause suicide and attempted suicide, especially by young people.

5.39 The Victorian Government continue to support the Victorian Coroner's initiative to establish the National Coronial Information System. (See section 5.10.1)

5.40 The Victorian Government require all funded initiatives related to suicide prevention to be independently evaluated to assess effectiveness of the outcomes and process for the project. (See section 5.10.1)

CHAPTER 6: EARLY INTERVENTION

6.1 The Victorian Government support the Department of Education to expand the number of professional counsellors available to support at-risk students. One professional counsellor should be located in each government secondary school who would be responsible for providing professional counselling services to students at the secondary school and its feeder primary schools, and for making direct links with the mental health promotion officer in each Department of Human Services region. (See section 6.1.1)

6.2 The Victorian Government support the Department of Education and the Department of Human Services to develop effective and ongoing linkages between schools and local community services based on the principles established by Keeping In Touch with Schools and An Extra Edge program, including establishing and maintaining multidisciplinary student support teams to provide coordinated health and welfare services to at-risk students in local school clusters. (See section 6.1.1)

6.3 The Victorian Government support the Department of Education to expand the number of places available for young people in the Planning for Employment and Training program. (See section 6.1.2)

6.4 The Commonwealth and Victorian Governments provide recurrent funding to allow consolidation and expansion of those models developed under the Innovative Health Services for Homeless Young People program that have been evaluated as being successful. (See section 6.1.3)

6.5 The Victorian Government support the Department of Human Services to expand youth support services based on models of best practice, such as the Youth Outreach Program, for adolescents at risk of, or involved in, illegal or offending behaviour. (See section 6.1.3)

6.6 The Victorian Government support the Department of Human Services to establish and evaluate a case management service for extremely high-risk young people leaving statutory care. This would be designed to assist and support them to successfully manage the transition from care to independence, and to provide post-statutory care support. (See section 6.1.4)

6.7 The Victorian Government support the Department of Human Services to expand and develop further sexual assault services for males. (See section 6.2)

6.8 The Victorian Government support the Department of Human Services to expand services for victims of sexual assault based on the best practice principles of continuity of care and outreach services that promote recovery of mental health and reduce the likelihood of self harm by the victims. (See section 6.2)

6.9 The Minister for Health require all government-funded drug and alcohol agencies to provide training for workers in identification, assessment and referral of those at high or immediate risk of suicide. Drug and alcohol and mental health services should be provided in a culturally sensitive way that better meet the needs of high-risk individuals with a dual disability. (See section 6.4)

6.10 The Minister for Corrections continue initiatives in the area of maintaining effective screening procedures for prisoners at risk and those with special needs at the time of their intake and prior to release from correctional facilities. (See section 6.5)

6.11 The Minister for Corrections ensure that correction officers in prisons develop post-release individual management plans for all prisoners considered at risk of suicidal or self-harming behaviours to effectively link them to community-based mental health and other support services. (See section 6.5)

6.12 The Minister for Corrections and the Minister for Health consider ways to expand the availability of culturally appropriate drug and alcohol and mental health services to mainstream prisons. (See section 6.5)

6.13 The Victorian Government, in collaboration with the Commonwealth Minister for Health and, where appropriate, the Australian Medical Association, support the development of youth-focused models of health practices that provide access to coordinated health, welfare and other services. The models should particularly target access to general practitioners by young males and should be overseen by local Divisions of General Practice. (See section 6.6)

6.14 The Minister for Health request the Divisions of General Practice to encourage general practitioners to undertake appropriate training to acquire accredited qualifications in mental health. (See section 6.6)

6.15 The Victorian Minister for Health take up with the Commonwealth Government changes to the Medicare rebate to appropriately remunerate mental health consultations undertaken by general practitioners with recognised mental health accreditation. (See section 6.6)

6.16 The Victorian Minister for Health take up with the Commonwealth Government the need for Divisions of General Practice to give priority to mental health requirements when funding special projects. (See section 6.6)

6.17 The Victorian Government, in collaboration with current telephone counselling services and the private sector, support the existing telephone counselling network to establish a 24-hour dedicated crisis/suicide prevention information help-line, including a 008 telephone contact for people in rural areas. The service would:

- Provide information, referral and crisis counselling for potentially suicidal people and their families and friends.
- Have the capacity to achieve three-way telephone communication between the caller, telephone counsellor and referral agency at all times.
- Include a capacity to refer urgent cases to immediately available counselling, medical, psychiatric and other services as required. (See section 6.7)

6.18 The Victorian Government support the Department of Human Services to establish after-hours and outreach services to complement 24-hour telephone counselling services for people in crisis. (See section 6.7)

CHAPTER 7: INTERVENTION SERVICES

7.1 The Minister for Police and Emergency Services investigate the need for access to multidisciplinary support for police in responding to depressed or suicidal individuals. (See section 7.1)

7.2 The Minister for Health require that Health Care Networks and regional and rural hospitals and health services establish and widely disseminate guidelines to public hospitals, ambulance services, health professionals, community support agencies and police to ensure suicide attempters gain access to care, appropriate referral and follow-up. (See section 7.3)

7.3 The Victorian Government support the Department of Human Services to appoint a psychiatric nurse or other appropriate mental health professional to emergency departments in public hospitals to:

- Assist with assessment and management of suicide attempters who present to emergency departments and are not admitted or are only admitted overnight.
- Develop referral plans.
- Establish and monitor follow-up procedures.
- Educate other emergency staff in dealing with persons who are suicidal. (See section 7.3)

7.4 The Minister for Health require Health Care Networks and regional and rural hospitals to implement procedures that ensure:

- A follow-up management plan for suicide attempters is established and communicated to all relevant health professionals involved prior to the person being discharged from hospital.
- Significant family members or carers are consulted in developing the management plan and that the plan is clearly communicated to them. (See section 7.3)

7.5 The Minister for Health initiate pilot research into innovative depression treatment approaches for adolescents. (See section 7.4)

7.6 The Minister for Health request that the Commonwealth review Medicare guidelines with a view to extending the qualification for Item 319 to those patients with a psychiatric illness who have reached or exceeded 50 attendances in a 12-month period but who continue to be, or who become, suicidal. (See section 7.4)

7.7 The Minister for Health develop rural and regional counselling services that focus on the needs of Koori people and males in small and isolated communities. (See section 7.4.2)

7.8 The Minister for Health investigate the potential for improving mental health services in rural areas through use of community nurses, appropriately trained, and adoption of the West Australian suicidal youth referral structure. (See section 7.4.2)

7.9 The Victorian Government support the Department of Human Services and the Department of Education to establish and evaluate a program in each Department of Human Services region along the lines of the Brief Intervention Program, linked to a Child and Adolescent Mental Health Service and/or Adult Mental Health Services and other appropriate services. (See section 7.4.3)

7.10 The Minister for Health require that existing Adult Mental Health services place greater emphasis on the care of young people aged 16 to 24 years who are mentally ill and/or at risk of suicide. (See section 7.4.4)

7.11 The Minister for Health establish guidelines and appropriate training for clinical staff to ensure smooth transition of clients from Child and Adolescent Mental Health services into Adult Mental Health services. (See section 7.4.4)

7.12 The Minister for Health implement procedures so that any person with suicidal ideation or who has attempted suicide, seeking admission to a psychiatric facility, who does not meet the Mental Health Act requirements and where a voluntary admission is inappropriate, should be immediately and directly linked to community mental health outpatient and follow-up services. (See section 7.4.5)

7.13 The Minister for Health expedite the establishment of a specialist statewide service for people with personality disorders to provide a range of options including hospital treatment, and to broker relevant community services prior to discharge. (See section 7.4.5)

7.14 The Minister for Health require mental health services to develop guidelines for mental health clinicians regarding provision of information on treating mental illness and supporting families and carers to assist them to manage the situation in the home. (See section 7.4.5)

7.15 The Victorian Government support the Department of Human Services to expand the role and number of Crisis Assessment and Treatment and Mobile Treatment and Support teams to deal with attempted suicide and other behavioural and psychiatric illnesses that do not require hospital care. This should include additional team members with expertise in providing mental health services to young adults aged 16 to 24 years. Priority should be given to improved effectiveness of Crisis Assessment and Treatment and Mobile Treatment and Support teams in rural areas. (See section 7.4.6)

7.16 The Victorian Government support the Department of Human Services to establish, in each of its administrative regions, community residential support services and day programs, linked to Child and Adolescent Mental Health services and the young adult program within the Adult Mental Health services, for young suicide attempters who are discharged from hospital and/or not considered in need of hospital care, to provide short- to medium-term care and outreach support services. (See section 7.4.7)

CHAPTER 8: POSTVENTION SERVICES

8.1 The Victorian Government collaborate with the business and community sectors to support the establishment of a widely advertised, statewide, community-based support service that provides:

- **Twenty-four hour suicide crisis support to relatives and friends immediately following a death by suicide. This service should be accessible to rural and remote areas, and be staffed by professionals and by volunteers who are trained to provide support.**
- **Capacity for longer term counselling in addition to immediate post-trauma counselling. (See section 8.1.3)**

8.2 The Minister for Youth and Community Services and Attorney-General continue to support counselling and other groups that assist people who have experienced a suicide, including close family, extended family, same-sex partners and significant friends. (See section 8.2)

8.3 The Minister for Youth and Community Services and Attorney-General consider options to make available bereavement counselling and support services for groups whose culture may require a different approach. These groups include non-English speaking background groups and Koori people. These groups should be involved in developing services for their communities. (See section 8.2)

8.4 The Victorian Government support departments and government-funded agencies to provide compulsory post-trauma counselling and debriefing services to all staff involved with suicides, particularly for those who witness or discover a person who has died by suicide. (See section 8.7)

8.5 The Victorian Government support the Department of Human Services to issue all potential emergency responders with information and protocols reflecting best practice in dealing sensitively with relevant matters relating to survivors of suicide immediately following the death of a person by suicide. (See section 8.7)

CHAPTER 9: IMPLEMENTATION STRATEGY

9.1 The Victorian Government support implementation of Victoria's Suicide Prevention Strategy by establishing the following framework for coordination:

- A Cabinet subcommittee of senior government Ministers to oversee implementation of the report's recommendations and development of ongoing policy.
- A senior Minister with lead responsibility for coordinating action to prevent youth suicide.
- Appointment of a senior adviser to support the Minister.
- Establishment of a Victorian Foundation for Prevention of Suicide. (See section 9.1.2.4)

9.2 The Minister for Health and Minister for Youth and Community Services invite tenders for delivery of client services as service partnerships or consortia of services that demonstrate the capacity to provide integrated client-oriented services based on the principles outlined in the report. (See section 9.4.1)

9.3 The Minister for Health and Minister for Youth and Community Services require the Department of Human Services to collaborate with other government departments to plan and provide direct services as integrated service packages to meet client needs, wherever possible. (See section 9.4.2)

9.4 The Minister for Health and Minister for Youth and Community Services require the Department of Human Services to ensure that no client is excluded from accessing service/s on the basis of regional boundaries. (See section 9.4.2)

9.5 The Minister for Health and the Minister for Youth and Community Services identify an appropriate structure that appoints a primary case manager or broker for people with multiple needs where there is a dispute with service providers. (See section 9.4.3)

9.6 The Minister for Health and Minister for Youth and Community Services implement an extensive program of performance and quality assurance audits, including site visits and client surveys, for all government-funded services relevant to suicide prevention to ensure organisations are providing the type, standard and quality of service for which they were funded, and to obtain feedback from consumers. (See section 9.4.3)

9.7 The Victorian Government establish a program of small grants to support initiatives that increases coordination and collaboration of regional and local service agencies. (See section 9.4.4)

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