2007

Parliament of Tasmania

Joint Standing Committee on Community Development

Report

On

Strategies for the Prevention of Suicide

Membership of the Committee

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Chairman's Foreword

Tragically, each year dozens of Tasmanians will take their life. Many others, it is likely, will have unsuccessfully attempted suicide or self-harm, and countless others may have seriously thought about it. The problem is much bigger than the statistics allude to and, possibly, the community is willing to openly recognise. This report does not, and was not intended, to find answers to all the questions about suicide.

However, this report does open up the answers to other questions. What is happening to prevent suicide? What strategic approach does Tasmania need? Who has a responsibility to do something about preventing suicide? How could high suicide rates among males be addressed? What research is needed? How much relevant and useful data is available?

This report – of the Committee's own initiative – provides guidance for how Tasmania should proceed to put in place the necessary strategies and mechanisms that will, hopefully, reduce suicide in the State. The report carries a strong message that more must be done and that greater attention to the issue of suicide is necessary.

Committee Members will monitor what develops in the future. While suicide may be an issue that the general community would perhaps prefer to avoid, it is something of vested interest for those it has affected.

The Committee wishes to express its appreciation to those who took the time to give evidence, to write a submission, or to provide requested information.

Hon. Kerry Finch MLC
Chairman
Joint Standing Committee on Community Development
November 2007

Anyone in need of assistance can contact:

Lifeline: 13 11 14
Lifelink Samaritans: 1300 364 566
Kids Help Line: 1800 551 800

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GLOSSARY OF TERMS

ABS	Australian Bureau of Statistics
APC	Australian Press Council
DHHS	Department of Health and Human Services
DPM	Department of Psychological Medicine (within a hospital)
LIFE	Living Is For Everyone
MHS	Mental Health Services
NACSP	National Advisory Council on Suicide Prevention
NCIS	National Coroner's Information System
NGO	Non-government organisation
NSPS	National Suicide Prevention Strategy
OH&S	Operational health and safety
RHH	Royal Hobart Hospital
TSPSC	Tasmanian Suicide Prevention Steering Committee

EXECUTIVE SUMMARY

Suicide and self-harm is a serious issue in Tasmania. During 2005-2006, there were 73 cases of mortality attributable to suicide in Tasmania, the same as the number of deaths caused by vehicle accidents in the same period. In previous years, suicides have outnumbered vehicle accident deaths.[1]

It is also reasonable to presume, though there is limited data available, that there are significant numbers of people in Tasmania who have inflicted self-harm, have had suicidal feelings, or have unsuccessfully attempted suicide at some point in their lives.

Suicide is a very complex problem. There is no single explanation for why it occurs and why a person may decide to end their life, and this was reflected in the evidence presented to the Committee.

The main question the Committee has been faced with is whether suicide prevention programmes and projects are more important to prevention than research and data collection in order to better understand the problem. If more is known about suicide, strategies can be properly formulated to achieve a reduction in suicides, but on the other hand, research and data collection does not amount to actual prevention activity.

In the opinion of the Committee, at this time, primary focus should be on developing and putting in place a Tasmanian suicide prevention strategy (including a plan of action), as well as addressing the issues that restrict the progress of people and organisations working to diminish the prevalence of suicide.

Data collection and research, however, should not be neglected: this needs to continue in order to ensure strategies remain effectual in the long-term. Some funding should be specifically provided for suicide research and data collection in Tasmania.

The Committee is not in a position to assess whether, at present, an appropriate level of funding is provided for suicide prevention in Tasmania. Funding may not be the whole answer; but incidentally, the Committee was unable to ascertain how much funding (from government and non-government sources) is available for suicide prevention in Tasmania, and what proportion of this money spent is on data collection and research. Funding for suicide prevention appears to come from a variety of sources, and the concept of ‘prevention’ does encompass a range of activities.

Levels of funding may not necessarily correlate with a high or low rate of suicide. Other factors, such as cultural and social conditions, ultimately have to change.

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[1] Magistrates Court of Tasmania ‘Annual Report 2005-2006’, November 2006, pp. 91-92, table 24

Tasmania needs a suicide prevention strategy. Making such a strategy effective will require significant work and engagement. There will no doubt be a number of problems to overcome, and reducing suicide will not necessarily be easy and is likely to be a long-term process. The outlook may seem be to some extent unfavourable, but the only clear choice is to undertake an intensive effort.

Nobody can avoid the issue of suicide, and everybody will have to participate in solving the problem. Generally, people have become more open about, and perhaps increasingly knowledgeable of, the issue of suicide in recent times. Individuals can make a difference simply by treating other people well, and especially by improving the social support networks around those on the trajectory of risk.

The role of governments and communities in relation to suicide prevention is ill defined at present. While something should be done to prevent suicide in Tasmania responsibilities seem to be divided between and amongst governments and communities. Therefore, it is difficult to know who is actually responsible for which aspects of suicide prevention, and consequently who is fulfilling their responsibilities properly.

More services specifically for men are needed. Males are overrepresented in suicide statistics in Tasmania; this is a major gap that needs addressing. The nature of men not to communicate or seek help for personal problems can make it difficult for service providers to have the opportunity to offer assistance.

Generally, data collection and research into suicide in Australia and particularly Tasmania appears to be limited. The Committee is of the view that more can be done in this area.

The intention of this report is not to apportion blame for the suicide rate being at its present level. Commendable work is happening. Nevertheless, the Committee finds that the strategic approach to preventing suicide in Tasmania could be more effective, and that present efforts fall short of what is needed. A suicide prevention strategy for Tasmania should, *inter alia*, delineate responsibilities of governments and government agencies, empower NGOs, and build the capacity of communities.

The Committee recognises that there is no single solution to suicide, but nobody should be resigned to failure on this issue.

CONCLUSIONS AND RECOMMENDATIONS

At the end of each chapter, conclusions (findings) have been compiled, from which the Committee has drawn its recommendations. For the convenience of the reader, all the conclusions and recommendations have been listed in sequential order below with reference to the chapter to which they relate. There are a total of 21 conclusions and 16 recommendations.

CONCLUSIONS

Chapter 1, the effectiveness of current strategies

1: The State Government shows an interest in the problem of suicide in Tasmania; however, it has yet to put in place an operational suicide prevention strategy. The TSPSC is a worthwhile concept, but has limits on its scope and function.

2: While the State Government may rely on the national strategy for direction, this appears to be without due consideration of specific Tasmanian requirements, which may differ from the national context.

3: Government and non-government sectors alike face a number of barriers and benchmarks to cross in order to make a suicide prevention strategy effective, although, a number of these seem to have an artificial existence and could be remedied. (It is possible, however, that ineffective strategies may exist.)

4: There is recognition that in order to make strategies relevant to local communities and regions, and various demographic groups, suicide prevention should not necessarily be conducted through any universal method or approach. There is also recognition, though, that a whole-of-population approach to the issue of suicide remains necessary.

5: If it is the case that individuals become suicidal due to other personal problems and circumstantial issues, the activities of the whole community is relevant to suicide prevention.

Chapter 2, Term of Reference 1: The role of government agencies, non-government organisations, the media, local communities, and businesses in progressing suicide prevention in Tasmania

6: Apart from funding for specific projects under the NSPS, the Committee could not determine an approximate amount of both government and non-government sources of funding for suicide prevention in Tasmania. The distribution and allocation of funding for suicide prevention is rather *ad hoc*.

7: The TSPSC fulfils a positive role for suicide prevention efforts in Tasmania. The TSPSC Reference Group may serve a useful way of networking, but it

could become laborious to effectively coordinate and manage as its membership enlarges.

8: The police and hospitals can be the last remaining source of help for people who are suicidal. The importance of their role cannot be underestimated.

9: Communities, as well as governments, should be concerned for and look after the wellbeing of community members.

10: NGOs and community organisations have an important suicide prevention role. In Tasmania, there are organisations and groups that have formed with the prime objective of suicide prevention, and others with wider objectives in other social issues that are increasingly taking on a suicide prevention role.

11: A number of avoidable issues inhibit suicide prevention efforts of NGOs and community organisations, which distracts from the overall objective of preventing suicide.

12: Employers, unions, and workplaces can assist in the suicide prevention effort. Present efforts occurring in this area seem positive, and further opportunities exist.

13: Evidence presented to the Committee on the impacts of suicide education and awareness programmes directed at young people calls for caution in this area. The role of teachers is important in terms of monitoring the wellbeing of young people.

14: It is important to continue recruiting graduates into mental health in Tasmania, and to encourage some graduates to undertake higher degrees in topics related to suicide prevention.

15: The role and responsibility of the media is to ensure the incidence of suicide is not exacerbated or inappropriately presented to the public.

16: Suicide is an issue that is covered by national industry guidelines that are self-regulatory, and the media have some scope to interpret these guidelines depending on the circumstances if they so desire.

Chapter 3, Term of Reference 2: The investigation of strategies in relation to the needs of men in Tasmania

17: Men have difficulty communicating with other people about their personal problems. This compounds the effort to bring assistance to them and to identify men in the community who need help.

18: Some services are available specifically for men in Tasmania, but it is unfortunate that more do not exist.

Chapter 4, Term of Reference 3: Determining the availability of data collection resources and opportunities for research to identify state specific trends

19: While the amount of research and data collection on suicide in Tasmania may be less than ideal, it nevertheless serves an indirect role in suicide prevention. Increased knowledge about suicide allows for more effective prevention.

20: The Coroner's Office is the primary source of information on deaths in Tasmania, and this information is further analysed by other government agencies and researchers. Non-government organisations may choose to collect some information about their clients.

21: For various reasons, not all the data that is collected on suicides in Tasmania is necessarily made available to the public, although the TSPSC could include more quantitative data in its annual reports than it presently does.

RECOMMENDATIONS

Chapter 1, the effectiveness of current strategies

1: The Tasmanian Government urgently needs to put in place a suicide prevention strategy for Tasmania. Such a strategy should have the flexibility to be relevant to local communities and the general population, and should also aim to change community attitudes.

2: A framework should be adopted to provide a useful strategic performance indication of suicide prevention progress for Tasmania, in absolute and comparative terms, and according to broad objectives.

Chapter 2, Term of Reference 1: The role of government agencies, non-government organisations, the media, local communities, and businesses in progressing suicide prevention in Tasmania

3: The State Government must seek to expand its suicide prevention role beyond its present scope as an area of priority if it wishes to address the unfortunate high prevalence of suicide in Tasmania.

4: The distribution and allocation of funding for suicide prevention in Tasmania has to be improved. The TSPSC may be able to assist and advise how governments at all levels could find solutions to this problem.

5: NGOs and community organisations should consider establishing a body independent of the TSPSC to serve as a point of coordination, strategic cohesion and leadership for non-government suicide prevention efforts, and

also to provide a second opinion to governments on how to reduce suicide in Tasmania.

6: NGOs should be encouraged to expand their suicide prevention services, and measures should be taken to reduce and overcome unnecessary impediments to suicide prevention activities, including through the provision of:

> 6a: Government funding for long-term (rather than short-term) periods of time for suicide prevention activities;
>
> 6b: Improved access to resources, current research, and training opportunities;
>
> And
>
> 6c: Increased promotion and recognition of organisations and the suicide prevention services they offer.

7: Efforts of employers to care for the wellbeing of employees should be intensified. Suicide prevention must be treated as a higher priority workplace safety issue. Unions should also make a contribution.

8: Suicide prevention and awareness education in schools should continue in terms of professional development for teachers, but should be approached very carefully if directed at students.

9: Graduates need to be encouraged into the mental health field in Tasmania, and in particular for research into suicide. Incentives, such as a scholarship for high-level research into suicide prevention, ought to be offered for Tasmanian graduates.

10: The Tasmanian media must ensure that the reporting of suicide is responsible, and as a standard practice contact details of counselling and support services should always be cited. The media should also ensure that content presented relating to suicide themes in general programming is also suitable.

<u>Chapter 3, Term of Reference 2: The investigation of strategies in relation to the needs of men in Tasmania</u>

11: Services that specifically aim to prevent suicide among men should be increased.

12: Men need to be encouraged to seek help if they are enduring emotional and personal problems.

13: Any future suicide prevention strategy (or strategic planning) in Tasmania must seek to address the prevalence of male suicide and male attitudes to approaching personal problems.

Chapter 4, Term of Reference 3: Determining the availability of data collection resources and opportunities for research to identify state specific trends

14: More research into suicide in Tasmania, whether funded by government or non-government sources, would be useful, though it should not be excessive and overshadow actual suicide prevention activities.

15: Funding should be specifically provided for research into suicide and periodic analysis of suicide data in Tasmania, which should be conducted by a body independent of the TSPSC that would provide an alternative Tasmanian-based source of research and data analysis. The TSPSC could continue to produce its own research and data analysis.

16: Tasmania should work to achieve greater consistency of data collection across all jurisdictions in order to enhance data collection capabilities to improve research into suicide prevention.

INTRODUCTION

ESTABLISHMENT

In November 2004, the Joint Standing Committee on Community Development ("the Committee") agreed to conduct an inquiry into strategies for the prevention of suicide.

A reference for an inquiry can arise via three sources: a Government Minister; either House of Parliament; or Members of the Committee. In this case, the reference for the inquiry was a request from Members of the Committee.

TERMS OF REFERENCE

Pursuant to a decision of the Committee on 12 June 2007 to slightly modify the original terms of reference[2] for this inquiry, this report is presented in accordance with the following terms of reference:

The Committee will examine the effectiveness of current national and local strategies in addressing the issue of suicide and suicide prevention in Tasmania in a range of settings with particular attention to:

1. The role of government agencies, non-government organisations, the media, local communities, and businesses in progressing suicide prevention in Tasmania;

2. The investigation of strategies in relation to the needs of men in Tasmania;

3. Determining the availability of data collection resources and opportunities for research to identify State specific trends;

4. And any other relevant matters.

BASIS FOR THE INQUIRY

Members of the Committee decided to undertake an inquiry into strategies for the prevention of suicide in response to the unfortunate high suicide rate in Tasmania, in order to review and assess the efforts that are being undertaken to prevent suicide.

The Committee desired to consider and investigate whether the current strategic approach is effective, and also to examine some particular issues.

[2] The original terms of reference are contained in appendix 1

Furthermore, Members of the Committee are hopeful that this inquiry and its report will help bring attention to what is a serious problem in Tasmania.

PROCEEDINGS

The Committee sought and received public submissions during May 2005. Public hearings were held periodically held from May to November 2005, and also during April 2007.

A wide range of views was presented, and the Committee expresses its appreciation to those who took the time to provide evidence in person or to prepare information in writing.

Details of submissions, witnesses, and documents received are contained in the appendices to this report.

STRUCTURE OF THE REPORT

The report is structured around the terms of reference. The first chapter focuses on the overall question of “the effectiveness of current national and local strategies” and each subsequent chapter addresses the particular terms of reference.

As no other pertinent issues have arisen that could not be included elsewhere under the terms of reference as they stand, there is not a chapter dedicated to “other relevant matters”.

Conclusions (findings) and recommendations are listed in a consolidated list at the beginning of the report and also at the end of each chapter as they relate to the terms of reference.

SUICIDE IN TASMANIA: A STATISTICAL OVERVIEW[3]

Numbers

For the year 2007 up to October, there have been 53 suicides in Tasmania (at this stage, nearly all remain unconfirmed). From 1978-2006, there were 1,985 suicides[4] in Tasmania.

Year	Number	Year	Number	Year	Number
2006	71[5]	1996	67	1986	69
2005	75[6]	1995	66	1985	70
2004	83	1994	74	1984	51
2003	74	1993	82	1983	69
2002	70	1992	97	1982	59
2001	72	1991	67	1981	65
2000	65	1990	69	1980	45
1999	86	1989	59	1979	56
1998	74	1988	72	1978	49
1997	61	1987	68	*TOTAL*	1,985

Regions

According to the TSPSC, from 1978 to 2004 50.3% of suicides occurred in the South, 28.8% in the North, and 20.9% in the North-West.

More recent data provided to the Committee shows this trend to have remained basically consistent for 2005, 2006, and 2007.

Age Groups

The breakdown of suicides by age group categories according to the TSPSC is as follows:

Age Group	%1978 to 2004	% 2004
15-29	28.4	18.7
30-44	30.6	37.3
45-59	21.4	27.7
60-74	13.4	7.2
Under 14/Over 75	6.2	9.6

The Committee has been provided with other figures categorised by different age group categories (15-24, 25-39, 65+, and ‘others’). This appears to show that from 1998 to 2007, people aged 25 to 64 accounts averagely for about two-thirds of suicides in Tasmania with the other third fairly evenly split between young people and elderly people.

[3] Statistics for this section have been sourced from the TSPSC Annual Report 2004/2006 pp. 24-34; and information provided to the Committee by DHHS in October 2007 (document 36).
[4] 32 from 2005 and 2006 remain unconfirmed.
[5] 20 unconfirmed
[6] 12 unconfirmed

Gender

From 1978 to 2004, the TSPSC has reported that males accounted for 80% of suicides in Tasmania during this period.

Other information provided indicates that in 2005, 2006, and 2007 (up to October) the proportion of male suicides has been less than this long-term average, and that there has been a small increase in the proportion of female suicides.

Per Capita Rate

The suicide rate per 100,000 of the population is as follows (selected years):

Year	Tasmania	Males	Females
1978	11.73	17.3	6.24
1980	10.62	16.61	4.7
1985	15.81	25.02	6.73
1990	14.93	27.04	3.01
1995	13.74	21.32	6.74
2000	13.79	22.46	5.86
2004	17.22	27.74	6.96
Average, 1978 to 2004	14.87	24.1	6.06
2005	15.46		
2006	14.49		

Methods

According to the TSPSC, from 1978 to 1994, the principle method of suicide was gunshot (44%), followed by hanging and asphyxiation (16%), carbon monoxide (16%), poisoning (13%), and other methods (11%).

Other information received shows that trends in method of suicide from 1995 to 2007 have changed. The principle method of suicide was hanging and asphyxiation (33%), followed by carbon monoxide (26%), gunshot (18%), poisoning (12%), and other methods (11%).

Indigenous Population

Information received by the Committee indicates that the recent suicide rate of indigenous people in Tasmania appears to be comparable to the non-indigenous population. During the period 1 January 2001 to 31 December 2006, 3.83% of suicides in Tasmania were identified as Aboriginal or Torres Strait Islander.

Suicide in Australia[7]

In 2005, there were a total of 2,101 suicides in Australia. The rate per 100,000 of the population for males was 16.4 and for females 4.3.

[7] ABS 'Suicides, Australia, 2005', 3309.0

CHAPTER 1
THE EFFECTIVENESS OF CURRENT STRATEGIES

Introduction

Tasmania does not have a suicide prevention strategy document *per se*, though nonetheless the State Government has had an actionable role through the Tasmanian Suicide Prevention Steering Committee (TSPSC). At this time, the State Government has considered itself implicitly obliged to support the principles of the Australian Government's 1999 National Suicide Prevention Strategy (NSPS).

Determining the effectiveness of a suicide prevention strategy is difficult, complex, and subject to a number of variables. The issues a strategy has to overcome include: accessibility to clients; a possibly unrealistic perception that results will be quickly noticeable, and achieved at reasonable cost; a suicide rate that meanwhile may fluctuate for unknown reasons; appropriate population coverage; adequate performance against interstate and international strategies; and communities that may not be functioning well.

In such circumstances, the outlook may appear challenging, and the concept of an effective strategy an idealistic one. Although, as Chapter 2 illustrates, the Committee has heard evidence from representatives of a number of NGOs and community organisations that shows positive work is happening in Tasmania.

Also, it appears that other social problems and population health issues have a significant relevance to suicide prevention.

Status of Current Government Strategies

Tasmania, at this time, does not have a stand-alone suicide prevention strategy. Although, a document provided to the Committee by the Department of Health and Human Services states:

> "The State Government supports the National Suicide Prevention Strategy and implicitly the LIFE Framework Action Areas as the basis for the suicide prevention strategy in Tasmania. … In line with the NSPS, the State supports a comprehensive suicide prevention strategy that seeks to address the broad continuum – health promotion/prevention, early intervention, intervention, and post-vention."[8]

DHHS has, according to this same document:

> "Established the Tasmanian Suicide Prevention Steering Committee as the central body to provide high-level advice to the Minister for Health

[8] Document (no. 2) provided by DHHS, p. 1

> and Human Services and other stakeholders on suicide and self-harm prevention. … The TSPSC provides expert advice and support to a range of suicide prevention projects, with a view to encouraging whole-of-government and whole-of-community participation in suicide and self-harm prevention."[9]

The TSPSC, according to its annual report, is developing an operational plan and undertaking a statewide community consultation process, "which will feed into a future Tasmanian Suicide Prevention Strategy."[10] The most recent TSPSC Annual Report states that the type of suicide prevention activity that works most effectively "extends beyond" clinical intervention:

> "It is a broad continuum of activity that consists of health and wellbeing promotion, suicide prevention training and education, early intervention, crisis intervention, and post-vention work with individuals, families, communities, and social groups."[11]

In its written submission, TasCOSS stated:

> "There is a need to ensure that there are clear links between services, programmes and policies so that suicide prevention strategies are well-integrated, coordinated, and potentially more effective."[12]

A national suicide prevention strategy (NSPS) has been put in place (known as LIFE – Living is For Everyone). The Parliamentary Secretary to the Federal Minister for Health and Ageing *inter alia* submitted to the Committee an overview of its strategy:

> "Under NSPS, the Government has committed approximately $10m annually since 1999 for the development of national and community models of suicide prevention. Over 170 community-based time-limited projects have been funded in States and Territories, according to locally identified priorities."[13]

Currently, the LIFE framework has six "action areas" of suicide prevention activity:

1. Promoting wellbeing, resilience and community capacity across Australia;

2. Enhancing protective factors and reducing risk factors for suicide and self-harm across the Australian Community;

3. Services and support within the community for groups at increased risk;

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[9] Document (no. 2) provided by DHHS, p. 3
[10] TSPSC *Report 2004/2006* (DHHS, Hobart, 2006), p. 8 (document no. 29)
[11] TSPSC *Report 2004/2006* (DHHS, Hobart, 2006), p. 13 (document no. 29)
[12] TasCOSS, submission, p. 5
[13] Pyne, submission, p. 1

4. Services for individuals at high risk;

5. Partnerships with Aboriginal and Torres Strait Islander peoples; and

6. Progressing the evidence base for suicide prevention and good practice.[14]

There are also four broad goals:

1. Reducing deaths by suicide across all age groups in the Australian population, and reducing suicidal thinking, suicidal behaviour, and the injury and self-harm that result;

2. Enhancing resilience and resourcefulness, respect, interconnectedness and mental health in young people, families and communities, and reducing the prevalence of risk factors for suicide;

3. Increasing the support available to individuals, families and communities who have been affected by suicide or suicidal behaviours; and

4. Extending and enhancing community and scientific understanding of suicide and its prevention.[15]

The LIFE *Areas for Action* document outlines what strategies should not do:

> "It is crucial that activities do not harm. Some activities that aim to protect against suicide have the potential to increase suicide amongst vulnerable groups. Well-meant messages may cause harm because they may be interpreted differently by different groups. Awareness of this potential is of particular importance in programmes that involve schools, the media, or raising awareness of suicide. All approaches need to be market-tested and carefully evaluated for negative as well as positive outcomes."[16]

In relation to the four above-mentioned goals, six strategic performance indictors are identified in the *Areas for Action* document:

1. Reduced rate of suicide death in the Australian population;

2. Reduced incidence of non-fatal suicidal behaviours;

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[14] Commonwealth Department of Health and Aged Care, *A Framework for Prevention of Suicide and Self-harm in Australia: Areas for Action* (Dept of Health and Aged Care, Canberra, 2000), p. 21 (Submission 8c)
[15] Commonwealth Department of Health and Aged Care, *A Framework for Prevention of Suicide and Self-harm in Australia: Areas for Action* (Dept of Health and Aged Care, Canberra, 2000), p. 16 (Submission 8c)
[16] Commonwealth Department of Health and Aged Care, *A Framework for Prevention of Suicide and Self-harm in Australia: Areas for Action* (Dept of Health and Aged Care, Canberra, 2000), p. 17 (Submission 8c)

3. Reduction of probable (and potentially modifiable) risk factors for suicidal behaviour;

4. Enhancement of probable (and potentially modifiable) protective factors for suicidal behaviour;

5. Enhanced community capacity; and

6. Increased investment in development, research, and evaluation of suicide prevention strategies that support a national strategic direction.[17]

The *Areas of Action* document also outlines a number of considerations for suicide prevention strategic planning, and states that planners should:

> "Consider not only the strength of a particular risk factor for individuals, but also how common it is in the community. Activities that focus on a relatively rare factor that places an individual at high risk may have a smaller effect on overall suicide rates than a programme that focuses on a lower-risk but relatively common factor."[18]

Four Tasmanian NGOs have been funded under the NSPS until June 2009, receiving in total about $1.73m.[19]

Impediments to Effectiveness

Access

Preceding the question of whether strategies are effective is the issue of access. If people who are in need of assistance cannot be linked to the services they need, effectiveness, to a large extent, becomes a secondary matter. Therefore, an important aspect of developing effective prevention strategies is addressing the issue of accessibility.

Problems of access tend to fall into two categories: firstly in terms of people who cannot find an appropriate service, and secondly in terms of people who seek a service but find that the provider does not have the capacity to help them.

Peter O'Sullivan (Lifelink Samaritans), told the Committee:

> "There is no sense in us having a service there that people do not know exists. …There are a lot of kids out there who do not have access to

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[17] Commonwealth Department of Health and Aged Care, *A Framework for Prevention of Suicide and Self-harm in Australia: Areas for Action* (Dept of Health and Aged Care, Canberra, 2000), pp. 18-19 (Submission 8c)
[18] Commonwealth Department of Health and Aged Care, *A Framework for Prevention of Suicide and Self-harm in Australia: Areas for Action* (Dept of Health and Aged Care, Canberra, 2000), p. 21 (Submission 8c)
[19] Information provided to the Committee (document 31) from the Tasmanian Office of the Commonwealth Department of Health and Ageing

> phones or mobiles or do not even read to know about services like ours."[20]

Wendy Quinn (DHHS Rural Health Division, past TSPSC chair) stated that as a result of compiling a database of services pursuing suicide prevention, two findings had been apparent. Firstly, while it was found that "a lot" of services existed, secondly:

> "We were picking up that a lot of people do not know that they exist and do not know how to access those services when they need them."[21]

The Committee asked Constance Alomes (Lifeline), if there was an unmet demand for services:

> "Yes, 50 percent of our callers cannot get through. …We will never get 100 percent of the calls. We are looking to get 85 percent."[22]

Nonetheless, it was pointed out to the Committee that even if Lifeline were able to expand its capacity, people would still need access to a phone.[23] The Committee was told that residents of certain disadvantaged areas of Launceston with service shortages, if in need of help and unable to find a working phone box nearby, would probably have to go to hospital:

> "The only place that we know of and the only place that is available at this stage is Ward 1E at the Launceston General Hospital."[24]

Measuring Effectiveness

The effectiveness of suicide prevention strategies is difficult to measure, for a number of reasons. Any success that does eventuate may not be immediate and suicide rates may nonetheless continue to inexplicably rise or fall. Strategies must also effectively target an appropriate quantum of the population and have to operate at a reasonable financial cost. Furthermore, even if this is achieved in Tasmania, the State may not necessarily have a suicide rate at or below the national average.

[20] Murphy, O'Sullivan, and Romanelli, transcript of evidence, 4 August 2005, p. 28
[21] Quinn, transcript of evidence, 10 May 2005, p. 6
[22] Alomes, transcript of evidence, 10 May 2005, p. 31
[23] Chapman and Coker, transcript of evidence, 4 August 2005, p. 95
[24] Chapman and Coker, transcript of evidence, 4 August 2005, p. 95

TABLE 1: SUICIDE DEATHS IN AUSTRALIA, selected years[25]		
Year	Total Number	Rate per 100,000 (age-standardised)
1921	621	14.0
1930	943	16.8
1943	516	7.7
1963	1,718	17.5
1980	1,607	11.6
1998	2,683	14.3
2005[26]	2,101	Males 16.4 Females 4.3
In 2004, there were 83 cases of suicide in Tasmania (7 unconfirmed), and the rate per 100,000 of the population was 17.22. The average suicide rate from 1978 to 2004 in Tasmania was 14.87.[27]		
For the period from 2001 to 2005, averagely, the Northern Territory had a suicide rate at more than double the national rate, Tasmania at 39% above, Queensland and South Australia at 14% above, and Victoria, NSW, and the ACT had rates below the national average.[28]		

Delayed Success

Suicide prevention strategies, the Committee was told, take time to have effect and new strategies may need up to ten years to have a measurable impact.

Renée Woodhouse (Suicide Prevention Strategy Officer, DHHS), said:

> "Strategies need to be mid-to long-term so between five to ten years, to actually have any sort of significant or real impact on the suicide rate."[29]

Martin Harris (University of Tasmania Department of Rural Health) said that governments should await results of suicide prevention efforts patiently:

> "The lead-time is extraordinarily long. You really need, I would think, an eight- or ten-year span of addressing a particular strategy before you start to see some results in the community."[30]

Variables Influencing Evaluation

Evaluating the success of suicide prevention strategies is problematic due to a range of variables that can affect suicide trends. The reasons why suicide rates go up or down appear, at least, to be complex, and are not entirely known. Also, the public and governments will be inclined assess a strategy from a cost-effectiveness perspective, even if research and statistics show it is successful.

[25] ABS, 'Suicides, Australia (1921-1998)', pp. 16-17, table 1, 3309.0
[26] ABS 'Suicides, Australia, 2005', 3309.0
[27] TSPSC *Report 2004/2006* (DHHS, Hobart, 2006), p. 25 and 32 (document no. 29)
[28] ABS 'Suicides, Australia, 2005, 3309.0
[29] Kirkby, Bent, and Woodhouse, transcript of evidence, 23 November 2004, p. 7
[30] Harris, transcript of evidence, 4 August 2005, p. 10

The Committee heard evidence from Ray Kemp (Project Manager, Information and Evaluation Unit of Mental Health Services) that definitively measuring success is very difficult. Members asked, whether based on the hard evidence, it was possible to know whether prevention efforts had been successful or not. He replied:

> "I do not know if there is any evidence to say whether we have been successful or not. … The population has increased but if you look at that rate it still has not changed. It fluctuates around the same level for a period of time. So there is probably some assumption to be made because I do not know how long suicide prevention programs have been actively run. There may be an indication that they might not be that effective. I don't know. … I am sure there are people worldwide researching these sorts of issues and I do not think anyone has really come up with an answer. … It is so complex. You can probably try to set in place programs that may be effective, but there is no program that will have an overall effect across the full range [of the population]."[31]

Furthermore, statistical data focuses on completed suicides, and reliable data on the number of suicides actually prevented cannot be reliably collected. How many people have been saved (over any period of time or place) appears to be unknown and would be difficult to find out, the Committee was told.

It was put to Mr Kemp that perhaps the numbers of people saved from self-harm ought to be published. He responded:

> "That is a difficult one; how many people each year are rescued, stopped from suicide."[32]

Tim Johnstone (Project Positive), said:

> "We cannot get attempts at suicide unless you do a specific closed study, and it is not going to be very effective. Risk-taking behaviour can be found out through other ways but is still not very clear. … We will never ever determine deliberate car crashes."[33]

The success of prevention strategies is measured not only against how many suicides are prevented, but also against how much money is spent to achieve results. Even if a prevention strategy has achieved results, or is likely to achieve results in the future, governments and taxpayers (rightly or wrongly) are not prepared for this to eventuate at an unreasonable cost over a long period of time.

According to Martin Harris:

> "One of the difficult things with suicide prevention and the one that Treasury always looks for is where are the results, where are the

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[31] Kemp, transcript of evidence, 14 June 2005, pp. 16-17
[32] Kemp, transcript of evidence, 14 June 2005, p. 17
[33] Johnstone, transcript of evidence, 4 August 2005, p. 52

> benchmarks? If you have spent all this money last year, why haven't suicides dropped to zero?"[34]

Nobody is prepared to fund programmes for ten years, he said. "Goodness me, that is three elections."[35]

Dr Chris Moorhouse (Executive Officer, Meander Valley Enterprise Centre and Rural Community Development Services) said that governments had been increasing the amount of money for suicide prevention, but results have not been forthcoming:

> "There seems to have been a poor correlation between the amount of money that all of us as taxpayers have put in to dealing with the issue of the problems of suicide and its reduction."[36]

Strategic Scope

Once a strategy has been developed for implementation, it has to be aimed across an appropriate breadth of the population. If an intervention is aimed at the whole community, it may reach some people in need, though conversely inconvenience and unnecessarily intervene in the lives of too many other people. If a strategy is too specific, it may produce a high return but overlook some people in need.

Ken Kirby (Professor of Psychiatry at the University of Tasmania) said that whole of population interventions are problematic:

> "The trouble is you would get a very low return on that particular intervention. That is the difficulty with population health."[37]

Les Whittle (Anglicare) said:

> "One of the dilemmas is that if we had a look at actual suicides and drew it as a pyramid, you would have a pyramid which is relatively small. If you then put in the base of attempted suicide, the bottom of the pyramid stretches out. If you then put in suicide ideation, it increases somewhat more. If you put in the rest of the population, it is a very big rest of the population, so to target the whole of the population isn't probably a good use of resources."[38]

If a strategy is narrowly targeted, it may reach a higher proportion of people in need, but others may be overlooked. Trying to accurately predict suicide is very difficult, and for that reason, it is also hard to achieve an ideal balance between a whole of population, low-return strategy and a very focussed, high-return strategy.

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[34] Harris, transcript of evidence, 4 August 2005, p. 10
[35] Harris, transcript of evidence, 4 August 2005, p. 10
[36] Moorhouse, transcript of evidence, 4 August 2005, p. 60
[37] Kirkby, Bent, and Woodhouse, transcript of evidence, 23 November 2004, p. 9
[38] Whittle and Lutz, 10 May 2005, p. 57

Amanda Stevens (Executive Officer, Tasmanian Association of Mental Health) suggested that what was needed was for a number of organisations to be involved in various specific projects, while the focus remained whole-of-population:

> "Tasmania is not doing a fantastic job but we are doing what we can with the limited resources that we have. … I am concerned that the focus has to be whole of population, with certain organisations and non-government organisations in that whole-of-population doing specific projects. I think if you lose the whole-of-population focus and concentrate on particular [sic] men or youth, then another area falls down. I think you have to keep the focus on whole-of-population."[39]

Reneé Woodhouse (Suicide Prevention Strategy Officer, DHHS) said:

> "In terms of suicide prevention strategies… it is important to have a combination of whole-of-population strategies in addition to strategies that focus on at-risk individuals."[40]

Professor Diego de Leo (Professor of Psychopathology and Suicidology, and Director of the Australian Institute for Suicide Research and Prevention) said there was "no profile for suicide". Among five people known to be at-risk, he said:

> "Statistically one will commit suicide. The problem is that we don't know which one of the five and these are the limits of our knowledge."[41]

Comparative Trends

Even if Tasmania is vigorously preventing suicide compared with decades ago, and lowers its suicide rate compared to the rest of Australia, this does not mean that Tasmania will compare strongly against the international situation or that present-day suicide rates will be lower than those of the past.

A number of witnesses sought to explain to the Committee how various societal conditions can affect suicide rates; what is noticeable or unique about Australian and Tasmanian trends in the worldwide context; how the nature of the world and world events at any particular time could impact on suicide rates; and how the suicide rate might not correlate with high or low levels of suicide prevention activity.

Martin Harris told the Committee there were various correlations and not "causal factors" influencing suicide rates:

> "Economic climate change, political change, social programs. There are all these really strange correlations. … But no one knows why and there are lots of correlations with war. Rates go down during wartime."[42]

[39] Stevens, transcript of evidence, 10 May 2005, p. 12
[40] Kirkby, Bent, and Woodhouse, transcript of evidence, 23 November 2004, p. 7
[41] De Leo, transcript of evidence, 15 November 2005, p. 15
[42] Harris, transcript of evidence, 4 August 2005, pp. 13-14

Professor de Leo said that people might set their life expectations too high:

> "The difference for a culture such as the Anglo [Saxon] is that you do not talk to any one so you are not communicating. You can talk, you can ring a friend only if you have something good to tell to this friend but if you feel a mess, if you feel a failure, if your girlfriend or wife or whatever… and you are not talking to anyone, then suicide becomes a very attractive option because it is an escape from an unbearable situation. … I don't think that it is the word of God that we don't have to tell others that we are a failure, that we feel horrible, that we are unable to do anything good, that we have no worth… We can say these things to people and people may accept us anyway. We don't all need to be successful, beautiful, rich, [and] full of muscles… We don't need these things and we can have a life that is equally rewarding."[43]

Suicide is not a problem in every country, Professor de Leo said.[44]

Ray Kemp stated:

> "Some international comparisons are also fraught. You get local problems and ways of dealing with suicide. For example, Japan has a different profile for suicide than some other developed countries. It has a cultural view of it."[45]

Dr Chris Moorhouse said that even though more money was being spent on suicide prevention, this had not necessarily produced results:

> "My understanding is that there is little evidence that the rates of suicide and in particular rural suicide, farmer suicide and young people suicide [sic], are in fact reducing in spite of the amount of the amount of time, attention and financial commitment that has been given to addressing those problems. It becomes therefore in my opinion quite important that we address suicide… at the upstream end where suicidal ideation may first appear in the minds of people; that we begin to think much more about the cause, not only of the suicidal act itself but of the kind of mindset, of the kind of ideation, that leads to the initial thoughts of suicide as a resolution to the kinds of difficulties, complexities, challenges and various other sociological, psychological, psychiatric factors that individuals are dealing with."[46]

TABLE 2: INTERNATIONAL SUICIDE TRENDS

From 1960-1964, the average male suicide rate (32 selected countries) was 16.5 per 100,000 of the population. From 1995-1999, the male rate was 17.6. The female rate has, for the respective time periods, declined from 7.7 to 5.6 per 100,000.

Research also shows that among countries that have introduced suicide prevention

[43] De Leo, transcript of evidence, 15 November 2005, p. 13
[44] De Leo, transcript of evidence, 15 November 2005, p. 4
[45] Kemp, transcript of evidence, 14 June 2005, p. 5
[46] Moorhouse, transcript of evidence, 4 August 2005, p. 60

strategies, the impact on suicide rates has been neutral or slightly negative.

Suicide Rates per 100,000, Selected Countries		
Country/Year	Male Age Group/Rate	Female Age Group/Rate
Canada/1998	15-24/21.6 25-44/26.0 45-64/27.8	15-24/5.1 25-44/6.4 45-64/7.8
United States/1999	15-24/17.2 25-44/22.4 45-64/21.3	15-24/3.1 25-44/5.7 45-64/6.1
New Zealand/1999	15-24/38.1 25-44/32.0 45-64/20.7	15-24/13.3 25-44/9.3 45-64/5.2

Source: De Leo, Diego, and Evans, Russell, *International Suicide Rates: Recent Trends and Implications for Australia* (Dept of Health and Ageing, Canberra, 2003)

In Tasmania, the average suicide rate per 100,000 from 1978 to 2004 was 14.87 overall (Male 24.1; female 6.06). (Source: TSPSC Annual Report 2004-2006 p. 32)

The 'Silo' Problem

Some witnesses told the Committee that the way funding is allocated does not engender coordination that ensures there are not gaps in services.

Irmgard Reid (Vision Across the Years Through Networking and Education [VYNE]), said:

> "I think really the issue of where effectiveness falls down is… when you work in silos, when you are not supporting each other in good practice, when there are competing agendas."[47]

Helen Barrett (Mind Matters State Project Officer, Department of Education), said:

> "I think that because of the way a lot of funding has come down; a lot of agencies are then forced into a very siloed approach because to meet particularly Commonwealth-funded requirements they have to fit into these boxes."[48]

Community Connectedness

Without the capacity of people to look after fellow members of the community, and if communities do not function well, the task of suicide prevention is not made easier. In such cases, suicide prevention not only involves helping individuals, but also assisting communities to create a positive environment.

[47] Todd and Reid, transcript of evidence, 14 November 2005, p. 12
[48] Barrett, transcript of evidence, 10 May 2005, p. 48

Professor Des Graham (Director, Mental Health Services, chair of TSPSC) said that levels of funding might not necessarily correlate with a lower suicide rate, but that community connectedness would:

> "I think the disclaimer to the funding is that, again, if we look at the literature and the success that we have had in terms of suicide prevention, it has not necessarily been associated with levels of funding. It clearly helped, and I will talk about funding specifically, but the rates of success are more attributed to the community connectedness."[49]

He continued:

> "Sometimes you do not need any more money to do that, you just need the services to open up or to be reconfigured in a different way… it is a process of connectedness."[50]

Dr Chris Moorhouse said:

> "Through community organisations, through social organisations, there is a great deal more to be done in my view. There is a great deal more potential than is currently manifest in our social and community support systems than currently exists."[51]

Irmgard Reid said that "ultimately" suicide prevention is about a broader perspective, involving the promotion of wellbeing and resilience and "a connected community."[52]

Coralanne Walker (Manager Kentish Health Centre) said:

> "The more we equip people within communities, the better off we are… they know their neighbours and their friends."[53]

Addressing Factors Indirectly Related to Suicide

Witnesses informed the Committee that social service providers in Tasmania are being confronted with growing numbers of clients who may have suicidal feelings, which are exacerbated or linked to other problems in their life – such as drug and alcohol problems, mental health issues, family or relationship breakdown and dysfunction, and financial problems.

If addressing factors indirectly related to suicide is considered part of the prevention effort, other strategies in wider social service areas could become relevant to the question of the overall effectiveness of suicide prevention.

Mat Rowell (TasCOSS) said:

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[49] Graham, Gavin, Papps, transcript of evidence, 20 April 2007, p. 6
[50] Graham, Gavin, Papps, transcript of evidence, 20 April 2007, p. 6
[51] Moorhouse, transcript of evidence, 4 August 2005, p. 63
[52] Todd and Reid, transcript of evidence, 14 November 2005, p. 12
[53] Walker, Chapman [R], Chapman [L], Johnson, Fairbrother, Hite, transcript of evidence, 3 August 2005, p. 40

> "There are 250 non-government community service organisations that provide a range of services to disadvantaged or vulnerable Tasmanians… whilst many don't have specifically funded suicide prevention programs, most report to us that on a daily basis they are seeing clients who present, for whatever reason, to their agency who have either attempted suicide, are thinking of attempting suicide or have been touched by someone who has completed a suicide. …it occurs across homelessness and housing services, alcohol and drug services, emergency relief and financial assistance services, and generic family support and youth services as well. This is further complicated in our sector by the fact that the complexity of clients presenting to our services has increased in the last number of years. … Separating alcohol and drug issues from mental health issues or homelessness from family violence issues is really quite difficult."[54]

Wayne Gaffney (CEO, Youth and Family Focus Inc) whose organisation primarily focuses on youth in need of accommodation, said:

> "A lot of the people we were working with were showing suicide ideation right the way through. So we would be there and someone in the shelter would be talking to one of the kids and suicide would come up."[55]

Jane Chapman, youth worker for Launceston northern suburbs community centre, and Sally Coker, a volunteer at the Ravenswood Neighbourhood House, said that low socio-economic conditions compound issues, due to the absence of support and services available to people living in these communities.[56]

Constance Alomes, (Lifeline), said many clients with suicidal feelings could reveal that they have other mental health problems as well, which are probably not being addressed.[57]

Tasmanians with Disabilities Inc submitted that:

> "Historically, people with disabilities are less likely to find and sustain satisfactory employment, and more likely to have lower self-esteem than others in the community. … Issues of disability and suicide are extremely complex, and are often linked."[58]

[54] Rowell, transcript of evidence, 10 May 2005, pp. 61-62
[55] Gaffney, transcript of evidence, 3 August 2005, p. 1
[56] Chapman and Coker, transcript of evidence, 4 August 2005, p. 92
[57] Alomes, transcript of evidence, 10 May 2005, p. 28
[58] Tasmanians with Disabilities Inc, submission, p. 2

Conclusions

(Chapter 1, the effectiveness of current strategies)

Status of current strategies

1: The State Government shows an interest in the problem of suicide in Tasmania; however, it has yet to put in place an operational suicide prevention strategy. The TSPSC is a worthwhile concept, but has limits on its scope and function.

2: While the State Government may rely on the national strategy for direction, this appears to be without due consideration of specific Tasmanian requirements, which may differ from the national context.

Impedients to effectiveness

3: Government and non-government sectors alike face a number of barriers and benchmarks to cross in order to make a suicide prevention strategy effective, although, a number of these seem to have an artificial existence and could be remedied. (It is possible, however, that ineffective strategies may exist.)

4: There is recognition that in order to make strategies relevant to local communities and regions, and various demographic groups, suicide prevention should not necessarily be conducted through any universal method or approach. There is also recognition, though, that a whole-of-population approach to the issue of suicide remains necessary.

5: If it is the case that individuals become suicidal due to other personal problems and circumstantial issues, the activities of the whole community is relevant to suicide prevention.

Recommendations
(Chapter 1, the effectiveness of current strategies)

1: The Tasmanian Government urgently needs to put in place a suicide prevention strategy for Tasmania. Such a strategy should have the flexibility to be relevant to local communities and the general population, and should also aim to change community attitudes.

2: A framework should be adopted to provide a useful strategic performance indication of suicide prevention progress for Tasmania, in absolute and comparative terms, and according to broad objectives.

CHAPTER 2
Term of Reference 1

THE ROLE OF GOVERNMENT AGENCIES, NON-GOVERNMENT ORGANISATIONS, THE MEDIA, LOCAL COMMUNITIES, AND BUSINESSES IN PROGRESSING SUICIDE PREVENTION IN TASMANIA

Introduction

Government agencies, NGOs, communities, the media, and businesses all have an important role to progress awareness, suicide prevention activities, and to provide safeguards. Education institutions, as part of the community, also have a role. Suicide prevention is an issue that has been given increased attention by various government agencies and the whole community, and generally, people have become increasingly open about, and perhaps more knowledgeable of, the issue of suicide in recent times.

The role of governments and communities in relation to suicide prevention is not clearly defined. While there is surely agreement that something must and should be done to prevent suicide in Tasmania, responsibilities seem to be fragmented between and amongst governments and communities. Therefore, it has been difficult to gauge who is actually responsible for which aspects of suicide prevention, and consequently to evaluate who is fulfilling their responsibilities properly.

The following section examines the scope and breadth of prevention suicide activities government agencies, NGOs, and businesses have claimed to provide, taking into account problems, issues, and barriers to prevention efforts that have been highlighted. In the case of hospitals and the police, they may have operational duties to fulfil in the event a suicide that has occurred, or being made aware of a person who is considered at serious risk.

The Committee has heard evidence from a number of key government agencies and NGOs, though by no means has full knowledge of the activities of any and all entities that are relevant to suicide prevention in Tasmania. In many cases, the Committee heard evidence from relevant witnesses in 2005, and circumstances may have developed or changed since then.

TSPSC and Other Government Agencies

The Tasmanian Suicide Prevention Steering Committee is operated under the auspices of Mental Health Services, a section of the Department of Health and Human Services. Other agencies with a role (through the police and coroners) are the Department of Police and Public Safety and the Department of Justice. A number of other Federal and State agencies may have a

broader or less-direct role. The Federal Government, through Carelink, has developed national coverage for a counselling and advice service.

TSPSC

Broadly, the role of the TSPSC is to coordinate, collaborate with, and bring together government and community representatives to guide and ensure overall suicide prevention effectiveness in Tasmania.[59] As well as the committee, which comprises mostly of government representative and three community representatives, a reference group has been formed, which has:

> "More diverse community representation to allow the Committee to consider a more extensive range of issues."[60]

Wendy Quinn (past TSPSC chair) was asked whether the reference group was sufficiently broad enough to properly look into the issue of suicide, and what else might be needed. She replied:

> "We continue to need to more properly communicate what it is and how people can be involved. People are scared. Often a number of the people who we need to have involved either have not heard about it yet, or need some careful explanation of what the reference group is. So they think they are being invited to join a committee, when in fact they are being invited to join a network of information, which they can engage with. So we believe we have the mechanism, but we do not think we have anywhere near the level of coverage that we could achieve with it."[61]

She also said the reference group (in 2005) had about 100 members.[62]

Dave Willans (Youth Network of Tasmania [YNOT]), was critical of the reference group concept:

> "I don't want to denigrate the work of that committee in any way. They are good people and they are doing very good work. The problem is a structural one. … I would argue that there needs to be a non-government coordinating body that has structural links to the Suicide Prevention Steering Committee. …I am not advocating any particular organisation; I just think that there needs to be an organisation that has that role. … I am on the reference group and the reference group is the body that the steering committee thinks can perform that coordinated role in the community sector and I think that is where they have things a bit wrong."[63]

Martin Harris (UTAS Dept of Rural Health), though, was supportive of the TSPSC:

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[59] TSPSC *Report 2004/2006* (DHHS, Hobart, 2006), p. 6 (document no. 29)
[60] TSPSC *Report 2004/2006* (DHHS, Hobart, 2006), pp. 10-11 (document no. 29)
[61] Quinn, transcript of evidence, 10 May 2005, p. 5
[62] Quinn, transcript of evidence, 10 May 2005, p. 4
[63] Willans, transcript of evidence, 10 May 2005, pp. 37-38

> "Regarding the suicide prevention steering committee, the one that Wendy Quinn chairs, over a number of years now she has brought to that table some interested parties across a range of departments and non-government organisations. I think that program needs to be supported and listened to because I think Wendy brings a very rational hand to those ideas."[64]

He also said that Western Australia has a ministerial council model that may be worth further investigation:

> "The Western Australians… have a ministerial council for suicide prevention, and this ministerial council might actually provide a model that is worth looking at, because it draws from Justice, from Education and from Health – I think they are the principal players – and they have a range of criteria that they look at in terms of trying to address the problem of suicide prevention in the west, and there are a number of satellite models that hang around the ministerial council."[65]

According to its most recent Annual Report, the aims of the TSPSC are as follows:

1. Provide leadership for suicide prevention activities for Tasmania, by:

    - Identifying areas of concern, in collaboration with other organisations;
    - Recommending areas for action, within state, national and community contexts; and
    - Providing a coordinated focus for government activity within Tasmania.

2. Provide and coordinate specialist expertise in suicide and suicide prevention;

3. Promote the collaborative development and support of suicide prevention activities in partnership with others with an interest and expertise in this area;

4. Promote and support research activity that will contribute to suicide prevention and minimisation of the adverse effects of suicide;

5. Support a sound evidence base for the development of programs and for use in practice, through:

    - Overseeing the maintenance and development of the specialist data base for suicides in Tasmania;
    - Providing an annual report on the data, comparing national and state trends and epidemiological data, for the Minister for Health and Human Services; and

[64] Harris, transcript of evidence, 4 August 2005, p. 11
[65] Harris, transcript of evidence, 4 August 2005, p. 2

- Acting as an exchange for information on suicide, suicide prevention activities and research findings.

6. Advise the Australian Government of specific Tasmanian issues relating to suicide prevention as requested.

7. Work collaboratively with the National Advisory Council on Suicide Prevention (NACSP) Board.[66]

Funding Issues

The TSPSC, at present, does not have responsibility for allocating funds from the Commonwealth Government to Tasmanian suicide prevention programmes and projects. The present chair of the TSPSC, Professor Des Graham, said that the Steering Committee should have some responsibility in this area:

> "Everyone in the mental health field is very grateful for the Prime Minister's commitment to the National Action Plan on Mental Health – the COAG initiatives. It is an enormous amount of money to be put into mental health services. It would have been great, however, if there was a conversation between the Commonwealth and the State to say, 'These are the priority areas for Tasmania. Can you channel your funds this way?' So, too, I think, in terms of suicide prevention; if the funds could potentially come from the Commonwealth into the Tasmanian Suicide Prevention Steering Committee then we feel we would be in a better place to say, 'These are our priority areas and this is the geographical distribution that needs to occur'."[67]

He also said that Tasmania should be better represented at the national level:

> "The suicide prevention subcommittee, which is called the community and expert forum, which Tasmania has some representation on, at the end of the day is not necessarily a decision-making committee. We want to be on the decision-making committee and we want to influence the decisions that are being made there."[68]

Wendy Quinn claimed that some funding had been acquired from the State Government for suicide prevention projects:

> "We have been in the situation where the State Government has been required or we believe that we have needed to advocate for ongoing funding for some of those program areas. We have had three of the projects where we have ended up finding a way to fund them with State government funding. … Our State government funding, our suicide-prevention-specific funding, has been relatively limited but that is not to say that there isn't a range of funding going into general health and

[66] TSPSC *Report 2004/2006* (DHHS, Hobart, 2006), pp. 9-10 (document no. 29)
[67] Graham, Gavin, Papps, transcript of evidence, 20 April 2007, p. 10
[68] Graham, Gavin, Papps, transcript of evidence, 20 April 2007, pp. 7-8

> community services and population health-based approaches that does not support the whole agenda."[69]

How much funding projects have received from the State Government and on what basis was not specified.

Mat Rowell (TasCOSS) said that funding for NGOs from State and Federal Governments was very *ad hoc*:

> "I think that the community sector is pretty disconnected and I think that is probably a product of the way that funding has been rolled out to the sector over the years. There is a multitude of funding programs in the State, with a multitude of organisations out there all vying for similar funding. We have some organisations that receive funding from 15 or 20 different line agencies in different State and Federal government departments. In the past that has essentially meant that State and Commonwealth agencies have not talked to each other about planning services. …There is no point in just putting services into places where there may already be services doing the same thing without communicating with each other."[70]

Wayne Gaffney (YFF) was asked how his organisation was funded. He replied:

> "A fair bit of time the State is handling Federal money. We have a couple of grants that are Federal. It is a mishmash."[71]

No witness was able to inform the Committee of an approximate figure of the total amount of funding (government and non-government) available for suicide prevention programmes and strategies in Tasmania. The Committee was not otherwise able to ascertain a figure. Similarly, the Committee could not ascertain how much funding is available for data collection and suicide research in Tasmania.

Police, Hospitals, and Coroners

The police, hospitals, and the Coroner's Court have roles to fulfil in an operational sense that contributes to suicide prevention. The police may be required to deal with an incident involving a person who is suicidal. The hospitals may be needed to treat a person who is suicidal. If a person has died as a result of a suspected suicide, the information collected by the Coroner's Court is used for the basis of Tasmanian mortality statistics, which can be subsequently utilised by researchers.

If police are concerned about a person's safety due to their state of mind, they have powers under the *Mental Health Act* to take them into custody. Tasmania Police Assistant Commissioner Scott Tilyard told the Committee:

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[69] Quinn, transcript of evidence, 10 May 2005, pp. 7-8
[70] Rowell, transcript of evidence, 4 August 2005, p. 11
[71] Gaffney, transcript of evidence, 3 August 2005, p. 8

> "We have authority under the *Mental Health Act* if we are concerned about the mental state of a person to take them into custody and to a place of safety for assessment. That is normally one of the main hospitals, the emergency management section of the hospital, where they are assessed by a psychiatric registrar and either admitted for observation or treatment or allowed to leave."[72]

He said Tasmania Police could access information relating to a person's mental health background for operational purposes, for dealing with incidents involving or related to self-harm.[73]

Sometimes, Assistant Commissioner Tilyard said, it is sufficient to take a person to a friend or family member's house rather than the hospital. Though he qualified this by saying that when individuals are taken to the hospital, they might be released after a short time:

> "It would be fair to say that there is occasionally some frustration that we feel as a police service when we are dealing with a person in what can be pretty extreme circumstances. We take them yelling and screaming to a hospital and wait around a number of hours for them to be assessed and basically they end up leaving about the same time as we do after someone has had a look at them. I am not being critical of the people involved in that process because they are more experienced and trained than we are to make that sort of assessment but there is the odd occasion when we feel that it might have been more appropriate to admit them than let them go."[74]

He said sometimes people who were released subsequently came to the attention of police soon thereafter:

> "There are certainly occasions where we might take someone to hospital and someone has a look at them and says, 'No, we do not think that they need to admitted'. Then we get called back to deal with them."[75]

Tasmania Police and DHHS have in place a memorandum of understanding, which aims to allow both agencies to have a "clear understanding and agreement of the roles and responsibilities of each" in relation to known clients.[76]

However, in evidence given, the Committee heard an allegation that the police could be slow to respond to calls from people to help a person who they believed was suicidal.

Sheree Edwards told the Committee:

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[72] Tilyard, transcript of evidence, 18 October 2005, p. 5
[73] Tilyard, transcript of evidence, 18 October 2005, pp. 7-10
[74] Tilyard, transcript of evidence, 18 October 2005, p. 5
[75] Tilyard, transcript of evidence, 18 October 2005, p. 5
[76] Tasmania Police/DHHS, 'Memorandum of Understanding and Working Protocols', December 2000; the Committee was informed in writing that this MOU is "currently being reviewed" (document 28).

> "When my son rang me and told me what he was going to do, I did not know where to turn. I rang the police in Smithton, because that is where he was, and they referred me through to the Penguin Police Station, and then I had to get [to] the Penguin Police Station, explain everything to them, and they rang the Smithton Police Station back and then I had to wait for the Smithton police to ring me, and it took us 12-and-a-half hours to find him. That is pretty horrific considering it was the police who took him to the hospital three weeks prior."[77]

Ms Edwards was asked to clarify if she thought the police had prior knowledge of her son's circumstances. She replied, "They knew, yes."[78]

Martin Harris said that he believed the police had had a "thin" understanding of suicide, but pointed out that police were now undergoing training to improve:

> "In fact, when I delivered that first round of training to the police, I could not get out of the car park. The police wanted to ask question after question. In most crisis moments they are the first point of call and they really don't have very much information or understanding. In fact the Commissioner came to the training and was sitting in the corner watching this to see whether it was a good idea to unleash me on his cadets. The first question I asked was to about 70 or 80 cadets was, 'How many of you have had close contact with a suicide [attempt] or a completed suicide?' and about 75 put their hands up. You could see the Commissioner's jaw dropping."[79]

Dr Ashley Ashley (Director of Psychological Medicine, Royal Hobart Hospital) said that sometimes the hospital could be overrun:

> "Often after hours there is nothing else available, so it all collapses at the Royal. … The questions I ask when I see patients include: are they psychotic or non-psychotic; do they have a medical condition; are they certifiable or not; can they give consent; are they treatable or is it just a matter of containment? The assumption for most of us is the worst-case scenario, requiring low risk and maximum impact."[80]

Dr Ashley said that there were times when "unwell" people were discharged before the weekends. He was asked if this was done to free up beds, and he replied, "Yes."[81]

Professor Diego de Leo said that "90%" of psychiatrists are in private practice, because they prefer to avoid the problems associated with public hospitals:

> "The public hospital clients are quite a different clientele from that of private hospitals, to be very frank. The most disadvantaged people going to the hospital: dirty, bad-smelling, of low education or whatever, but

[77] Edwards, transcript of evidence, 3 August 2005, p. 17
[78] Edwards, transcript of evidence, 3 August 2005, p. 17
[79] Harris, transcript of evidence, 4 August 2005, p. 4
[80] Ashley, transcript of evidence, 8 November 2005, p. 2
[81] Ashley, transcript of evidence, 8 November 2005, p. 5

> psychiatrists want to have blonde young girls, intelligent, witty, funny and making a lot of money with easy patients. In the public hospital you have a tough job; you have very hard patients, very tough, sometimes very violent patients, but not because they are mad and bad, but because they are scared. …The problem is the management of public mental health. The big numbers of suicide in this psychiatric sphere comes from the public psychiatric sphere."[82]

In the event that a person has died, the police will treat it as suspicious until otherwise determined. No assumption is made prior to an investigation.[83] Assistant Commissioner Tilyard told the Committee:

> "The responsibility of the police with regard to suicides primarily is to assist the Coroner in the investigation to establish the manner and cause of death. We provide all our police officers with the necessary training to allow them to do that from a response investigation capacity."[84]

He also said that measures are taken to assist and support officers who have been involved in traumatic situations.[85]

Jim Connolly (Coroner's Office) said that the coroner will investigate the cause of death and may then, by way of "preventative jurisdiction", make recommendations:

> "The coroner is required, under the Coroners Act, to find out who died, when they died and why they died. But they are also invited then to make recommendations. So you have findings about certain matters of fact, and then you have recommendations as to how systems or product design, or whatever the issue is, may be improved in future to avoid further deaths."
>
> …
>
> "One of our coroners, Rod Chandler, handed down findings into two deaths that occurred by way of suicide of patients who were in the Department of Psychological Medicine at the Royal Hobart Hospital. … His findings amounted to 16 pages, and he makes recommendations about procedures for the management of patients in the Department of Psychological Medicine. So there is definitely a role for the coronial jurisdiction to play."[86]

Coroners also record details about individuals who have died. This information is submitted to the National Coroner's Information System, which is a large database of national coronial information. Approved subscribers can then access this database.[87]

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[82] De Leo, transcript of evidence, 15 November 2005, pp. 7-8
[83] Tilyard, transcript of evidence, 18 October 2005, p. 1
[84] Tilyard, transcript of evidence, 18 October 2005, p. 1
[85] Tilyard, transcript of evidence, 18 October 2005, pp. 15-16; see also document no. 21
[86] Connolly and Scott, transcript of evidence, 10 May 2005, pp. 18-19
[87] Document (no. 10) provided by State Coroner's Office

Commonwealth Carelink
Carelink is a Commonwealth-funded agency that has shopfronts in various locations throughout Australia and provides assistance to people who may have any range of personal problems. It also has a telephone counselling service.

The Committee was informed:

> "Being part of a nationwide network can be a really valuable resource for the community as well. If somebody living on the north-west coast of Tasmania is concerned about a relative living in Darwin who has expressed suicidal thoughts to them over the telephone… they can ring us on the Commonwealth Carelink number. That call of course will come through to our local centre. We can transfer the call free of charge to the appropriate centre on the mainland. They can get information about counselling services that are available and applicable in that local area and they can get the assistance required. I see that our role is maintaining up-to-date information, having knowledgeable and skilled staff so that we can make appropriate referrals to the professionals in the particular geographical area and to provide a service of excellence to the community."[88]

NGOs and Local Communities

NGOs and local communities have an important suicide prevention role. The Committee spoke with representatives of a number of organisations operating programmes and projects that work to prevent suicide in Tasmania, including: Lifeline, Anglicare, Youth and Family Focus, Tasmanian Association for Mental Health, Parakeleo Industries, Lifelink Samaritans, Project POSTIVE, Time-Out, Vision Across the Years Through Networking and Education (VYNE), OzHelp, Tools for Men, and Tassie Male.

While excellent work is happening in the non-government sector to prevent suicide, NGOs have limits to their capacity. Representatives were able to share a variety of experiences with the Committee.

Youth and Family Focus submitted that:

> "NGOs generally have a strong community focus, are perceived as more accessible and less impersonal by clients, and are more often accessible to clients who would be reticent to use government organisations for service delivery. … Whilst not depreciating the role of the government or some of the larger organisations, it is the smaller, community-based organisations which we feel have the greatest impact on communities in suicide prevention."[89]

According to Tim Johnstone, NGOs do not have to worry so much about "red tape" and therefore fulfil an important role:

[88] Harding and Barwick, transcript of evidence, 3 August 2005, p. 44
[89] Youth and Family Focus Inc, submission, p. 2

> "The reason we believe it is important is that the non-government organisations can be supported by the Feds [Federal] or State [Governments], or whatever the case may be, to venture out to do the work that they simply cannot do in the government situation because they can step out of the usual guidelines that they have to follow in government."[90]

Some unhealthy competition exists or can easily develop between NGOs, the Committee was told. Dave Willans (YNOT) said:

> "Organisations tend to fight amongst each other or there is not the degree of collaboration and cooperation amongst all the organisations and between the government and non-government agencies that will give better outcomes for people who are at risk."[91]

Peter O'Sullivan (Lifelink Samaritans) said that professional service providers could sometimes be jealous of volunteer groups:

> "Sometimes professional groups can get very jealous of where they are sitting and what they do, and they do not want to be threatened by volunteers."[92]

Keith Todd (OzHelp) said that his experience in the ACT led him to believe that working together was important:

> "One of the things I have discovered in the ACT is that we have to work together. If you do not draw on all of those resources that you have and have them working collaboratively, then they all try and compete. They think they are competing for money. We had the same thing here, but I think we are breaking it down through communication."[93]

The Work of NGOs and Communities in Tasmania

The Committee heard a significant quantity of evidence in relation to non-government suicide prevention programmes and projects in Tasmania. NGOs may be for profit or not-for-profit, community-based, work generally within or also outside of Tasmania (or Australia), and greatly range in size and influence. The following section is intended to provide (in no particular order) a small insight of their profile, objectives, and day-to-day work in Tasmania, as presented in the evidence received.

Tasmanian Association for Mental Health

The Association operates Chance Camps and a club for children whose parents have a mental illness, as research indicates they are "at high risk" of themselves developing a mental illness:

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[90] Johnstone, transcript of evidence, 4 August 2005, p. 49
[91] Willans, transcript of evidence, 10 May 2005, p. 36
[92] Murphy, O'Sullivan, and Romanelli, transcript of evidence, 4 August 2005, p. 19
[93] Todd and Reid, transcript of evidence, 14 November 2005, p. 9

> "If either parent goes to work full-time then you have a child who takes on, to a certain extent, a caring role for that person. So they might miss out on school events, they might not do anything in the weekend because they feel that there is an obligation there to help mum or dad out when they are unwell. When either mum or dad are unwell, especially if there is a psychosis or some sort of bipolar disorder, the normal functioning of a family like cleaning, household chores, washing up and cooking meals, tends to be the thing they let go of first because they are trying to keep themselves well. You will find that a lot of children step up into those roles of making sure that the lunches are packed for the other siblings or that tea is prepared. They are only small things but that's a lot of pressure for a young child to have. … That is why they are at that higher risk."[94]

Lifeline

Lifeline offers a 24-hour counselling service, its primary focus, which is operated by both paid and voluntary staff. Calls from clients are confidential and anonymous:

> "The aim is to address the suicide risk and to bring help as close as the phone. We do have one telephone number and people can access that from anywhere for the cost of a local call. That is brilliant because you have people in remote and rural areas in Tasmania who can ring Lifeline and talk for 40 minutes without getting an STD charge. … We are the ones who are catching the people who fall through the cracks. We catch the people as that crisis starts to build and we also catch the people who are just hanging on with that one finger".[95]

Youth and Family Focus

YFF provides a range of services including crisis and transitional accommodation, mediation, drug services, and since December 2004 has branched directly into suicide prevention.[96]

Parakeleo Ministries

Parakeleo is a privately funded organisation under Churches of Christ in Victoria and Tasmania that provides a retreat centre in the North-West of Tasmania for people who need to spend time away. It also offers counselling services and counselling training as a means of generating money to operate the retreat:

> "Parakaleo runs a retreat centre where up to four people at a time can have some time out. It is not a therapy place. It is not a medical model. It is purely a place of time out where people for whom it is appropriate can spend up to seven days there within what we are calling a community of hope. Some people live on site as counsellors and as caretakers and

[94] Stevens, transcript of evidence, 10 May 2005, p. 10
[95] Alomes, transcript of evidence, 10 May 2005, p. 26
[96] YFF, submission, p. 1

> help in that community. People whom we feel appropriate can come and spend that short period of time out at that place."[97]

Lifelink Samaritans

Lifelink operates a 24-hour free-of-charge telephone befriending service in Tasmania and overseas that has no religious or political affiliation. It is a volunteer-based organisation that works from Launceston.[98]

> "Some of the calls can be from someone who hangs up or changes their mind as soon as we answer the phone, to people who stay on the phone for anything up to two hours. A number of those people are regular callers to our service."[99]

Project POSTIVE

POSITIVE stands for Prevention of Suicide Involving Tasmanians in Vital Education. It is a community-based organisation under the auspice of the Southern Midlands Council and receives Federal funding. It runs educational workshops to teach participants about the issue of suicide and how to recognise the signs of suicidal behaviour.

> "The project's aim is focussed on increasing the awareness, knowledge and confidence of people in some rural and regional communities of Tasmania in the prevention of suicide. By using a community development focus, the training acknowledges and further develops current community resources and identifying networks of people who come in contact with an at-risk person."[100]

Time-Out

The Time-Out Project serves young people between the ages of 14 and 28 who are at-risk of, or are recovering from, attempted suicide or self-harm. While not providing holiday homes, young people can be invited to stay at a retreat house for a weekend:[101]

> "We are just practical people who provide a service for the young people. We obviously do it well because it has now grown to the extent that we have a lot of young people coming from Hobart, from the coast… and they are happy to get on the bus and come up here… for a weekend. They get on the bus again and go back. It is great to think that they feel safe; they have probably never felt safe, apart from the weekend they have with us."[102]

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[97] Walker, Chapman [R], Chapman [L], Johnson, Fairbrother, Hite, transcript of evidence, 3 August 2005, p. 24
[98] Document provided by Lifelink Samaritans (no. 16)
[99] Murphy, O'Sullivan, and Romanelli, transcript of evidence, 4 August 2005, p. 18
[100] Document provided by Project POSITIVE (no. 17)
[101] Document provided by Time-Out (no. 18)
[102] Gee, McLaren, Stanton, transcript of evidence, 4 August 2005, pp. 83-84

Businesses, Workplaces, and Employment

Workplaces were identified by a number of witnesses as an area that suicide prevention could be pursued further, through both employers and unions.

Aside from the possibilities for suicide prevention in workplaces, unemployment, on the other hand, was cited as an issue that may exacerbate someone's personal problems and increase their suicide risk. Mat Rowell (TasCOSS) said that employment was a "key factor" in poverty and social isolation. He said that men aged 25 to 44 are particularly affected:

> "Sixty per cent of all Tasmanian men who are in receipt of unemployment benefits are in that age group, 40 per cent of all men on disability support pension are in that age group. So we have particular issues about that age group and if… [there was] a zero unemployment rate, then the poverty work would almost be done, as would some of the pressure on people who experience social isolation, a lack of support around them and are unable to provide financially for their families so they get themselves into states of despair."[103]

In its written submission, TasCOSS stated:

> "For those employed, the workplace is often a major connection point between the individual and society, and workforce participation is often an important element in the construction of self-image and self-esteem."[104]

Professor Graham said that more employers should take more responsibility for the wellbeing of their employees:

> "We think that there is absolute room for improvement not only in terms of the volume or the number of businesses or employers who take responsibility for the total wellbeing of their employees."[105]

Tim Johnstone said that workplaces could broaden the concept of workplace safety:

> "What I would like to believe is that you would be able to go into a factory and see posters up – which weren't around when I was a boy – saying, 'You must wear earmuffs and goggles'. There would be another one there saying something like, 'You must talk to a mate if you feel like crap'."[106]

Some witnesses told the Committee that having programmes in male-dominated workplaces (such as the construction industry) would be a way of accessing the high-risk male population, in particular males in their early 20s.

[103] Rowell, transcript of evidence, 10 May 2005, p. 68
[104] TasCOSS, submission, p. 4
[105] Graham, Gavin, Papps, transcript of evidence, 20 April 2007, p. 16
[106] Johnstone, transcript of evidence, 4 August 2005, p. 43

Ron Chapman (Parakeleo Industries) said:

> "I think one way of doing that is by equipping and empowering people with the information, suicide intervention information, the courses, particularly through workplaces. Of that particular age group, there is a better chance that they are involved in a workplace and so the more that workplaces can embrace suicide intervention as part of their overall caring for their people has to make a difference."[107]

INSERT 1: OZHELP FOUNDATION

In November 2005, the Committee travelled to the ACT and spoke with Keith Todd, a representative of the OzHelp Foundation.

OzHelp was founded following suicides of three apprentices in the construction industry in Canberra, and aims to bring together stakeholders in the industry to prevent further suicides through early intervention and prevention programmes.[108] According to a document provided by OzHelp:

"Through its training and support services OzHelp not only acts to prevent the tragedy of suicide in the community, it also directly improves things such as OH&S [operational health and safety], apprentice retention in the industry and general productivity in the workplace."[109]

Keith Todd said:

"Our target group is three-fold, which is the apprentices, the workers and then the industry culture. It started with the apprentices but it has gone a lot broader in the past three years.
…
My field officers wear the industry gear; they go out on industry work sites. One of our initiatives is called Oz Barbecue and we run barbecues on work sites to get our message out."[110]

Education and Educational Institutions

The role of schools in preventing suicide appears, to some extent, a contentious issue. The Committee heard evidence in relation to a programme designed to better equip teachers and schools to protect students from suicide. It was firmly put to the Committee, however, that suicide education in schools should not extend so far as to encourage students to manage the problems amongst each other. Distinction between 'suicide awareness' (problematic in a school situation) and protecting a young person from contemplating suicide (such as self-esteem issues and learning to seek help) is important. Also, higher education institutions in Tasmania have an

[107] Walker, Chapman [R], Chapman [L], Johnson, Fairbrother, Hite, transcript of evidence, 3 August 2005, p. 36
[108] Document provided by OzHelp (no. 12)
[109] Document provided by OzHelp (no. 12)
[110] Todd and Reid, transcript of evidence, 14 November 2005, p. 4

important role in terms of producing graduates who can work in the mental health field.

Awareness and Education in Schools

Views on this issue and the exact role of schools, teachers, and students and how they should work together were not always in agreement, and feelings appear to be strongly held.

Professor de Leo said that teachers and school counsellors should be trained to spot the signs of a student with problems:

> "You should train your school teachers to – I wouldn't say 'identify mental disorders' because that is not their role – at least identify signs of deviancy in broad terms. 'These scholars are not performing well because I have the impression that there is this and that'. Then you have the school counsellors who normally do very little. They can be trained better to cope with these problems and re-screen subjects when it is appropriate."[111]

Mary Bent (DHHS deputy secretary), said:

> "There is a range of activities that we do within schools, which is really important and is quite strong and will continue. There is a program called Mind Matters, which has been developed by the Commonwealth but implemented across the schools. We have provided some extra funding in Health to allow that to go from high school to primary school now because another issue we have noticed is that the older years in primary school are the ones now who need more support. They are growing up much faster than some of us think is right, speaking as a mother. So that puts mental health and mental wellness in the context of the entire health of the individual. It is not seen as something separate, but again, it also supports children and adolescents in particular in how to see the risk factors in their peers and gives the basic information about how to provide supportive groups."[112]

[111] De Leo, transcript of evidence, 15 November 2005, p. 17
[112] Kirkby, Bent, and Woodhouse, transcript of evidence, 23 November 2004, p. 8

INSERT 2: MIND MATTERS

Mind Matters is a project to promote knowledge of mental health in secondary schools in Australia. Packages of information have been delivered to most schools in Australia. Training courses are also available for teachers. The Committee heard evidence from Helen Barrett (Mind Matters Tasmanian project officer), who said schools have access to a model called Education for Life that covers issues related to suicide:

"It is a guide for schools in relation to dealing with suicide and self-harm and critical incident management. It has some really good information guidelines, advice, and evidence-based information in relation to how schools can respond in relation to suicide. The message that we give teachers with this one is that their role is not about being therapists or counsellors but about being aware of what those issues entail, being able to make clear referrals if they see that a student is in distress and needs counselling or further support."[113]

She also said that suicide can come into classrooms for "a whole range of reasons" and teachers need guidelines to know how to respond.[114]

Two witnesses impressed upon the Committee that any suicide prevention programmes in schools have to be approached very cautiously.

Martin Harris said that while some programmes have the "best intentions", their input might not be positive:

> "We get lots of programs that with all the best intentions. They want to get into communities and they want to raise the awareness and they particularly target the schools because it seems like a nice captive audience. These young people are already going through what we know is a fairly tumultuous period of their life in adolescence, but the work in schools awareness raising is quite alarming and I would caution you against that approach. It is all very well to talk to teachers and to guidance officers and those that are in charge of the young population but the teenagers have this morbid attraction to suicide as a topic of interest for all sorts of reasons… The research indicates that the most informed student populations are the most at risk."[115]

Tim Johnstone has similar views:

> "I am saying this because I would really like to have it on the record. It is very dangerous if… you ever get the notion in your head, that suicide prevention and education has to happen to under-18s by really pushing home to them how they have to help their mates if they are suicidal. It is just so dangerous. … There are some organisations who believe that is nonsense and that you can shock kids into making themselves available

[113] Barrett, transcript of evidence, 10 May 2005, p. 43
[114] Barrett, transcript of evidence, 10 May 2005, p. 43
[115] Harris, transcript of evidence, 4 August 2005, p. 9

> to assist their friends if they are suicidal. They are not emotionally ready for it."[116]

He was asked how such programmes enter into school environments, and responded:

> "Ill-informed principals of schools who don't realise. They think it would be really good for the kids to be involved. They can quite easily slip into the school and take over the school's environment before you know it. You have kids going around the school with a badge saying they are the assigned student, and any other students who have a problem can come and talk to them about it."[117]

Attracting and Retaining Graduates

Without graduates remaining in Tasmania to work in the mental health area, and other areas related to suicide prevention, future problems could arise.

Professor Graham said that Tasmania is "struggling not only to recruit but to retain". He said ways have to be found to provide incentives for young people to work in mental health:

> "If you are three years in an undergraduate program in New South Wales you can work in a mental health facility and they have in place graduate programs, whereas in Tasmania you have to do four-and-a-half years [to do postgraduate studies]. If you have to do four-and-a-half years to work in mental health, we are competing. … We ask our nurses in this State to jump twice as far. If we are not asking for nurses in accident and emergency to have postgraduate qualifications before they can work there, then why are we doing it for mental health? I think we need to make sure that we have good undergraduate programs that include mental health as a core component."[118]

Dr Ashley said there was a "failure" to recruit and retain psychiatrists.[119]

Professor de Leo and Linda Trompf (Director, ACT Mental Health Services) said that they supported the idea of setting up a scholarship for young students who want to pursue research into suicide and acquire a specialisation in that area.[120]

The Media

There was agreement among witnesses that the media could influence people in such ways that may encourage or discourage suicide, or unintentionally

[116] Johnstone, transcript of evidence, 4 August 2005, p. 55
[117] Johnstone, transcript of evidence, 4 August 2005, p. 55
[118] Graham, Gavin, Papps, transcript of evidence, 20 April 2007, p. 14
[119] Ashley, transcript of evidence, 8 November 2005, p. 5
[120] Trompf, transcript of evidence, 14 November 2005, p. 25; De Leo, transcript of evidence, 15 November 2005, p. 20

generate myths about suicide. No witness advocated imposing measures akin to censorship on the reporting of incidents of suicide. Although, the Committee was told that the media could have a positive contribution to suicide prevention if responsible reporting standards are followed.

Witnesses who work in the mental health and suicide prevention area recalled occasions of suicide being reported in ways that were unhelpful and inappropriate. They also recalled occasions of helpful and appropriate reporting. The Committee heard verbal evidence from the Australian Press Council and the editor of the Hobart *Mercury* newspaper to explain how the media approaches the issue of suicide.

Opinions of media and non-media witnesses largely agreed that the primary role of the media in relation to suicide prevention is to report it with sensitivity and caution, in a way that does not exacerbate the problem, and that as a matter of course stories related to suicide should contain contact details of counselling or support services. However, opinions of both viewpoints largely did not agree that these principles have been properly and consistently applied.

According to the most recent TSPSC Annual Report, "The bulk of evidence suggests that blatant reporting can contribute to suicide risk in vulnerable people."[121]

Guidelines, Regulation, and Standards of Reporting: The Media Viewpoint

There are various guidelines for reporting standards depending on the form of media (such as radio, print or television). The Mindframe Media project[122] is making a contribution to a better understanding of reporting suicide and mental illness responsibly, though adherence to its guidelines is voluntary.

The Australian print media is obliged to refer to Australian Press Council (APC) guidelines and standards for the reporting of a range of issues. The APC is a "self-regulating body" comprised of membership derived from the media, and resolves issues through "mediation and adjudication".[123] Guidelines have been developed that specifically address the reporting of suicide.

APC General Press Release no. 246 (i) of July 2001 suggests that editors consider including "reference to counselling services" when reporting suicide, and states that certain practices should be avoided:

> "Adding to the pain of relatives and friend of the deceased; any reporting which might encourage copy-cat suicides or self-harm; unnecessary reference to details of method or place of suicide; language or presentation which trivialises, romanticises, or glorifies suicide,

[121] TSPSC *Report 2004/2006* (DHHS, Hobart, 2006), p. 18 (document no. 29)
[122] See <http://www.mindframe-media.info/>
[123] Herman, transcript of evidence, 20 September 2005, p. 2

> particularly in papers which target youth readership; loose or slang use of terms to describe various forms of mental illness, and the risk of stigmatising vulnerable people that may accompany such labels."[124]

Jack Herman (APC Executive Secretary) said the APC makes a distinction between the phenomenon of suicide and individual cases.[125] He said there was more openness about suicide in recent times, but added that too much openness could be problematic:

> "The situation has changed in the print media over the last 20 years. Until about 20 years ago there was almost a tacit agreement, particularly in community newspapers, not to mention suicide at all. … That has to be balanced against the belief of mental health experts that too great a detail on method and whatever could have a copycat effect."[126]

The media could draw attention to the prevalence of suicide in neglected townships, he said, and subsequently services are brought to communities in need.[127]

He said that the most difficult suicides to report are those relating to well-known people. While the APC guidelines require individual cases of suicide to be dealt with carefully, he claimed reporting on a high-profile suicide is difficult to avoid:

> "The question that arises in the coverage of those things where you draw the line between the necessity to report and the desirability to report responsibly and not in a way that might encourage others to face similar action. … I cannot see any way that the newspapers nowadays can avoid reporting those things; the question is how responsibly they report them and whether or not they draw the attention of those people who read them to the possibility that the availability of counselling services will help them."[128]

The prominence of tragic stories in a newspaper does not improve sales, he said:

> "I haven't ever seen any study to indicate that putting the story of a tragic self-harm incident on the front page of a newspaper in fact increases the sales of the newspaper. My suspicion is that it creates the sort of feeling… of sadness and depression and that is not necessarily what makes people want to buy a newspaper."[129]

Overall, he told the Committee, "The Council's position is that the reporting in the press has largely been responsible".[130]

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[124] APC General Press Release no. 246 (i), 'Reporting of Suicide', July 2001
[125] Herman, transcript of evidence, 20 September 2005, p. 1
[126] Herman, transcript of evidence, 20 September 2005, p. 2
[127] Herman, transcript of evidence, 20 September 2005, p. 2
[128] Herman, transcript of evidence, 20 September 2005, pp. 3-4
[129] Herman, transcript of evidence, 20 September 2005, p. 5
[130] Herman, transcript of evidence, 20 September 2005, p. 1

Garry Bailey (Editor, the *Mercury*) claimed his newspaper, when reporting suicide, would probably "go beyond" the APC guidelines. Advice from health agencies was also used as a guide, he said. Although, he qualified this:

> "The first thing I have to say about all those, both the press guidelines and anything else that comes to us, they are not the rule book; the line in the sand varies day to day depending on the tide. I am talking about the tide of public opinion more than anything else, and what its effect would have on us as a newspaper, and what our community thinks. … In all my time at the *Mercury* – and I started there in 1969 – we have never reported incidents of suicide unless there has been a wider public effect as a result of the death. If, for example, there is a murder and the perpetrator then commits suicide, then clearly that needs to be reported."[131]

If suicide was reported, the "essential test" was public benefit, he said.[132] A suicide may fit into this category if it were subject to a coronial inquest or a death in the custody of state authorities (such as a prison or psychiatric ward).[133] Individual cases do not usually get reported:

> "If there were 80-odd deaths last year from suicide you could not say, 'you find me the stories, you find 80 stories in the *Mercury* or indeed any Tasmanian newspaper about them'. You won't – unless there are other things related to them, such as a murder or a siege, which we start reporting before anyone is killed and then someone may well take their own life as a result of it."[134]

Mr Bailey said that "as a matter of course" reference is made at the end of a suicide-related story to Lifeline and the Kid's Help Line, though it was uncertain whether this resulted in readers calling these services.[135]

Members of the Committee sought clarification as to why the *Mercury* had such a policy, and asked whether citing contact details was done as a precautionary measure as much as anything else. He replied:

> "We did it because they asked us to. Lifeline asked us to – 15 years ago, it is a long time."

He was further asked if it was necessarily proven that this practice assisted in reducing suicide. He responded:

> "I don't think you could say that, no, in merely just putting out a few numbers."

He agreed though, that this was a good thing to do.[136]

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[131] Bailey, transcript of evidence, 20 September 2005, p. 7
[132] Bailey, transcript of evidence, 20 September 2005, p. 13
[133] Bailey, transcript of evidence, 20 September 2005, pp. 12-13
[134] Bailey, transcript of evidence, 20 September 2005, p. 13
[135] Bailey, transcript of evidence, 20 September 2005, p. 15
[136] Bailey, transcript of evidence, 20 September 2005, p. 16

The *Mercury* has an in-house policy not to report details of incidents on the Tasman Bridge, he said:

> "The most asked question from readers is why don't we report what happened on the Tasman Bridge… and my answer always is that unless the effect is such that it caused major disruption to the city – and I think there were only two in recent times where it has – we are not reporting it, because there is no public benefit".[137]

He said, however, that if a suicide has occurred and must be reported, using "fuzzy" language and euphemisms does not always effectively conceal the fact:

> "Every reasonably intelligent reader, which means 99.9 per cent of them, knows exactly what we are talking about."[138]

The guidelines and rules that apply to the reporting of suicide do not necessarily apply to advertisements. He explained:

> "The rules, which I try to go by in reporting suicide in our newspaper, do not apply of course to the advertising area – and, of course, the only area where it will crop up will be in the death notices. Now if someone chooses to use the word suicide in a death notice – and I have no recollection of one appearing in any Tasmanian newspaper, let alone the *Mercury* – that is entirely up to the advertising department whether they should accept it. If the family wishes to use that and reveal that, it is really a matter for them. I don't think we can interfere."[139]

Garry Bailey shared the view of Jack Herman in relation to newspaper sales, saying that the *Mercury*'s biggest readership rise in recent times had been generated by the 200-year anniversary of the settlement of Hobart.[140]

Commercial television stations in Tasmania refer to the Television Industry (Free TV Australia) Code of Practice. Section 4.3.9 of that code states that broadcasters:

> "Should broadcast reports of suicide or attempted suicide only when there is an identifiable public interest reason to do so, and should exclude any detailed description of the method used. The report must be straightforward and must not include graphic details or images, or glamorise suicide in any way."[141]

WIN Television informed the Committee that it is "extremely rare" for the public interest test to be met. It also indicated that it supports suicide prevention awareness campaigns through its no-charge community service airtime.[142]

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[137] Bailey, transcript of evidence, 20 September 2005, p. 8
[138] Bailey, transcript of evidence, 20 September 2005, pp. 7-8
[139] Bailey, transcript of evidence, 20 September 2005, p. 8
[140] Bailey, transcript of evidence, 20 September 2005, p. 11
[141] Commercial Television Industry (Free TV Australia) Code of Practice, 2 July 2004, p. 33
[142] Document (no. 33) provided by WIN Television

Southern Cross Tasmania claimed to have a "general rule" not to report suicides. Its journalists, the Committee was informed, are assisted with training and resources to help them deal with reporting violence.[143]

Appropriate and Inappropriate Reporting: The Non-Media Viewpoint

The non-media viewpoint did not necessarily agree with some of the claims made by the media as outlined above.

Constance Alomes informed the Committee that Lifeline had requested the *Mercury* to include Lifeline's phone number at the end of a story related to suicide:

> "A few years ago we did make a request to the *Mercury* that, when they feature a story about self-harm, they put Lifeline's telephone number on the bottom of that because a key message needs to be that there is help."[144]

She was asked if Lifeline received cooperation. She replied:

> "Absolutely… Yes, very much so."[145]

Representatives from Lifelink Samaritans told the Committee that their organisation was not always cited in newspaper articles:

> "Quite often Lifeline aren't put in either and they should be."[146]

Professor Graham said that the *Mercury* had caused problems in the past. He told the Committee:

> "There were a couple of pages in the *Mercury* following some reporting of an individual who had jumped off the Tasman Bridge. … It was disgraceful and I thought it was unprofessional. There is an agreement about the reporting of suicides that was developed under the national mental health strategy between State mental health directors and the associated press… that the newspapers and media agreed to, and I thought that that article breached most of that agreement.
>
> We rang the *Mercury* and we said, 'We are not happy about this', so they sent us one of their head reporters and then we spent almost half a day with that person and said, 'This is what we see as sensible reporting'. In the following week they did a two-page spread for us about what was suicide and what was not suicide… We then made an offer to the *Mercury* to train their reporters that they want to put through and to date they have not taken that up. But what we do notice is that their reporting is much more sensible."[147]

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[143] Document (no. 32) provided by Southern Cross Tasmania
[144] Alomes, transcript of evidence, 10 May 2005, p. 32
[145] Alomes, transcript of evidence, 10 May 2005, p. 32
[146] Murphy, O'Sullivan, and Romanelli, transcript of evidence, 4 August 2005, p. 36
[147] Graham, Gavin, Papps, transcript of evidence, 20 April 2007, p. 15

Ray Kemp (MHS) said "It is not always the case that the media are as sensitive as we would like them to be."[148]

Tim Johnstone said that the media has to be "a lot more" responsible, and that irresponsible reporting had occurred:

> "One of the media outlets in Tasmania… has been causing strife because they have been out of order. I have done other work with other media outlets… I have made it very clear that there are guidelines that you must follow… before you print this so you do not get into trouble… So the media can play a very good role and can play a very bad role."[149]

Renée Woodhouse (MHS) said that sometimes suicide-related stories in the media had the potential to generate imitative behaviour if it was presented poorly:

> "If a story is handled poorly then we end up with copycat-type incidents, and there has been a series of incidents over the last few weeks that have caused us some considerable concern. We generally talk a lot to our media colleagues in relation to this, and we recognise and support them when they provide stories that actually assist us in our attempts to raise the awareness of suicide in the community and have a sympathetic approach to people with mental illness."[150]

Mary Bent (DHHS) and Ken Kirkby (Professor of Psychiatry, University of Tasmania) said that focus on a particular locality could start what is known as the "Werther effect", whereby a particular place (such as a river) becomes renowned as a popular location for suicides to occur.[151]

Dr Chris Moorhouse said that, at times, the media in general could be too negative of the world, and give young people the impression there is "not a lot to be lived for":

> "The things we are seeing, not only in the news media but also in the dramatic media, have to do with short-term consequences of things, short-term goals, ambitions, achievements and so on. I think we probably are selling our young people short by not imbuing within them a sense of life's continuity."[152]

Professor de Leo claimed that the media are "commercial enterprises" that "want to have success", which can result in insensitive reporting:

> "The only success was that at the end of each article now there is something about Lifeline… This was a step ahead, by the way, but it will be a very long process to use the media in such a way that they can favour suicide prevention."[153]

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[148] Kemp, transcript of evidence, 14 June 2005, p. 16
[149] Johnstone, transcript of evidence, 4 August 2005, p. 49
[150] Kirkby, Bent, and Woodhouse, transcript of evidence, 23 November 2004, p. 6
[151] Kirkby, Bent, and Woodhouse, transcript of evidence, 23 November 2004, pp. 14-15
[152] Moorhouse, transcript of evidence, 4 August 2005, p. 65
[153] De Leo, transcript of evidence, 15 November 2005, p. 10-11

TasCOSS submitted that the media:

> "Has a social responsibility to report issues and present stories in an ethical, honest, balanced and responsible manner."[154]

[154] TasCOSS, submission, p. 3

Conclusions

(Chapter 2, Term of Reference 1: The role of government agencies, non-government organisations, the media, local communities, and businesses in progressing suicide prevention in Tasmania)

TSPSC and other government agencies

6: Apart from funding for specific projects under the NSPS, the Committee could not determine an approximate amount of both government and non-government sources of funding for suicide prevention in Tasmania. The distribution and allocation of funding for suicide prevention is rather *ad hoc*.

7: The TSPSC fulfils a positive role for suicide prevention efforts in Tasmania. The TSPSC Reference Group may serve a useful way of networking, but it could become laborious to effectively coordinate and manage as its membership enlarges.

8: The police and hospitals can be the last remaining source of help for people who are suicidal. The importance of their role cannot be underestimated.

NGOs and local communities

9: Communities, as well as governments, should be concerned for and look after the wellbeing of community members.

10: NGOs and community organisations have an important suicide prevention role. In Tasmania, there are organisations and groups that have formed with the prime objective of suicide prevention, and others with wider objectives in other social issues that are increasingly taking on a suicide prevention role.

11: A number of avoidable issues inhibit suicide prevention efforts of NGOs and community organisations, which distracts from the overall objective of preventing suicide.

Businesses

12: Employers, unions, and workplaces can assist in the suicide prevention effort. Present efforts occurring in this area seem positive, and further opportunities exist.

Education and educational institutions

13: Evidence presented to the Committee on the impacts of suicide education and awareness programmes directed at young people calls for caution in this

area. The role of teachers is important in terms of monitoring the wellbeing of young people.

14: It is important to continue recruiting graduates into mental health in Tasmania, and to encourage some graduates to undertake higher degrees in topics related to suicide prevention.

The media

15: The role and responsibility of the media is to ensure the incidence of suicide is not exacerbated or inappropriately presented to the public.

16: Suicide is an issue that is covered by national industry guidelines that are self-regulatory, and the media have some scope to interpret these guidelines depending on the circumstances if they so desire.

Recommendations

(Chapter 2, Term of Reference 1: The role of government agencies, non-government organisations, the media, local communities, and businesses in progressing suicide prevention in Tasmania)

TSPSC and other government agencies

3: The State Government must seek to expand its suicide prevention role beyond its present scope as an area of priority if it wishes to address the unfortunate high prevalence of suicide in Tasmania.

4: The distribution and allocation of funding for suicide prevention in Tasmania has to be improved. The TSPSC may be able to assist and advise how governments at all levels could find solutions to this problem.

NGOs and local communities

5: NGOs and community organisations should consider establishing a body independent of the TSPSC to serve as a point of coordination, strategic cohesion and leadership for non-government suicide prevention efforts, and also to provide a second opinion to governments on how to reduce suicide in Tasmania.

6: NGOs should be encouraged to expand their suicide prevention services, and measures should be taken to reduce and overcome unnecessary impediments to suicide prevention activities, including through the provision of:

> 6a: Government funding for long-term (rather than short-term) periods of time for suicide prevention activities;
>
> 6b: Improved access to resources, current research, and training opportunities;
>
> And
>
> 6c: Increased promotion and recognition of organisations and the suicide prevention services they offer.

Businesses

7: Efforts of employers to care for the wellbeing of employees should be intensified. Suicide prevention must be treated as a higher priority workplace safety issue. Unions should also make a contribution.

Education and educational institutions

8: Suicide prevention and awareness education in schools should continue in terms of professional development for teachers, but should be approached very carefully if directed at students.

9: Graduates need to be encouraged into the mental health field in Tasmania, and in particular for research into suicide. Incentives, such as a scholarship for high-level research into suicide prevention, ought to be offered for Tasmanian graduates.

The media

10: The Tasmanian media must ensure that the reporting of suicide is responsible, and as a standard practice contact details of counselling and support services should always be cited. The media should also ensure that content presented relating to suicide themes in general programming is also suitable.

CHAPTER 3
Term of Reference 2

THE INVESTIGATION OF STRATEGIES IN RELATION TO THE NEEDS OF MEN IN TASMANIA

Introduction

Males are overrepresented in suicide statistics in Tasmania, as they are nationwide. This fact seems well recognised as a major problem that needs addressing. A reluctance of men to communicate and seek help for personal problems makes it difficult for service providers to have the opportunity to offer assistance. While a number of organisations offer services regardless of gender, it appears that only a few specialise in assisting men.

The Scale and Nature of the Problem

There is strong statistical evidence to show that in Tasmania, males are generally around four times as likely as females to complete a suicide. This has been an apparent trend for as long as records have been kept.

Witnesses were not in agreement as to which, if any, age groups of males were at risk. It was suggested that male suicide patterns could be generational, but there was not agreement on this point either.

There was also speculation about the reasons why men are a problem, and witnesses provided anecdotal and personal experiences to explain why men are over-represented in the statistics.

TABLE 3: MALE SUICIDE IN TASMANIA: STATISTICAL OVERVIEW

The male suicide rate in Tasmania is about four times higher than for females.

	Male Age Groups (0-14 removed) rate per 100,000, averages categorised by time periods					
Period	15-29	30-44	45-59	60-74	75+	Total
1978-1986	28.23	28.24	27.97	31.34	34.84	21.4
1987-1994	38.42	31.09	30.4	34.71	39.88	26.12
1995-2004	31.52	38.23	29.01	21.17	35.73	24.56

From 1978-2004 the female rate in Tasmania, averagely, was 6.06 per 100,000.

Males represented 80% of suicide deaths in Tasmania from 1978-2004 (1,470 out of a total of 1,838 cases). In 2004, males accounted for 79% of suicide deaths (66 out of a total of 83 cases).

During 1995 to 2004 in Tasmania, there were noticeable differences in the methods

of suicide for each gender. The main methods of suicide for females were poisoning (23%), hanging and asphyxiation (26%), and carbon monoxide (26%). Among males during the same period, the main methods of suicide among males were hanging and asphyxiation (31%), carbon monoxide (30%), and gunshot (22%). Only 3% of female suicide deaths were by gunshot during that period.

Source: TSPSC Annual Report 2004/2006, pp. 24-25 and pp. 32-33

In 2005, there were 53 male suicides (70.6%) and 22 female suicides. In 2006, there were also 53 male suicides (74.5%) and 18 female suicides.

Source: Information provided by DHHS (document 36)

According to Wendy Quinn (past TSPSC chair):

> "The area that I have the most current concern about is the area of 24 to 45-year-old men, who last year [2004] took up almost half of the statistics in terms of the suicides in this State."[155]

Ray Kemp (MHS) suggested the notion that males aged 25 to 44 were most at-risk was an assumption only; and needed research:

> "That is only supposition based on what the statistics are showing us and looking at what could be causing it. There is a broad range of issues there and certainly it is a fertile ground for some significant research."[156]

Jan Murphy (Lifelink Samaritans) said older males were at high risk:

> "The men at risk are the much older group and who have all the means to do it. They have the tablets there. Their spouse has gone, their dog has died and there is very little we can latch onto to say, 'Please stay here'. They have lived their life, their friends are all gone and they just want to end their lives. That is part of euthanasia, I suppose, when you think about it. They are a high suicide risk."[157]

Tim Johnstone (Project Positive) said indigenous males were most at risk:

> "Statistically in Australia, indigenous males are the highest risk factor. The second point is the indigenous community of Australia, and no exceptions for Tasmania, are at the highest risk of self-harm through alcoholism and high-risk taking behaviour, so that being the case it is a high-risk group."[158]

Martin Harris (UTAS Rural Health) told the Committee it was possible a generation of males were a higher risk:

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[155] Quinn, transcript of evidence, 10 May 2005, p. 8
[156] Kemp, transcript of evidence, 14 June 2005, p. 15
[157] O'Sullivan, Romanelli, Murphy, transcript of evidence, 4 August 2005, p. 26
[158] Johnstone, transcript of evidence, 4 August 2005, p. 42

> "They were 20 and 29 a decade ago and they were 13 to 19… They are in their mid-30s now. … And there is statistical evidence now to suggest that there is a cohort factor in that. Ten years from now we wonder if the ones 40 to 49 will be doing the same thing. The spike seems to be moving through. …I think that is ripe for some more investigation."[159]

Professor Diego de Leo (Professor of Psychopathology and Suicidology, and Director of the Australian Institute for Suicide Research and Prevention) agreed that nationally, males aged 25 to 44 were most at-risk:

> "The people at risk in Australia are indeed males aged from 25 to 44."[160]

Members asked if there was substance to the claim that a cohort effect was moving through the male statistics. He responded:

> "It is possible."[161]

He said the factors behind the risk of males aged 25 to 44 was more likely related to circumstances of men's lives during that age, such as separation, financial difficulties, or "failing their entrance to society".[162]

He was asked if, in 20 years' time, this same age group would be a problem. He replied: "Yes."[163]

Issues Specific to Men

Communication was highlighted as a key problem for men. Without the ability to communicate to someone that they need help, men complicate their situation. Service providers told the Committee they find it difficult to identify men who require assistance. Giving men the skills to communicate, therefore, was identified as one place to start in this area. Unemployment among men was also mentioned as a factor contributing to the suicide risk of men.

Nonetheless, there appeared to be some degree of uncertainty surrounding the specific needs of men who are in crisis.

It was also suggested to the Committee that all men might not have the same needs, and that the approach of service providers will need to vary depending on the circumstances.

Linda Trompf (Director, ACT Mental Health Services) said:

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[159] Harris, transcript of evidence, 4 August 2005, p. 13
[160] De Leo, transcript of evidence, 15 November 2005, p. 6
[161] De Leo, transcript of evidence, 15 November 2005, p. 23
[162] De Leo, transcript of evidence, 15 November 2005, p. 23
[163] De Leo, transcript of evidence, 15 November 2005, pp. 23-24

> "I do not know that anybody has a ready answer to this problem, but again I stress one of the major issues for men is getting them to acknowledge that there is an issue and to actually seek help."[164]

Wendy Quinn said interventions for men aged 25 to 44 were difficult:

> "We really have very little information about what is going on for these men and how to access them in terms of prevention programs. …It is a group of people who don't normally access health services in the same way that older people or younger people or women do."[165]

Keith Todd, (OzHelp) said that programmes for men had to focus strongly on relationship development, because it took time to encourage openness:

> "We have a whole counselling service but we actually identify the fact in the way our service is set up that men will not go to doctors. Men will not go to a counselling service. We are a short step because we are there. We are in their face. My field officers wear the industry gear; they go out on industry work sites. One of our initiatives is called Oz Barbecue and we run barbecues on work sites to get our message out. Through those small steps, at the end of three years on, we have had people who turn up on our doorstep on their RDO [rostered day off] and say 'I want to talk to somebody'."[166]

Professor de Leo said that men aged 25 to 44 do not contact telephone counselling services such as Lifeline:

> "These individuals, especially when suicidal, do not call Lifeline – zero. There are no calls from these people. Lifeline can claim the contrary but they don't call Lifeline."[167]

Constance Alomes (Lifeline) however, stated that most Lifeline callers aged 25 to 44 were usually women, although "that ratio is changing a bit" and more than one third of calls now come from men:

> "It used to be that maybe only one-quarter were men and three-quarters were women, but now more than a third would be men who seek help."[168]

Witnesses also explained to the Committee that men are not all alike, and that it is difficult to know how to most effectively access males in need of assistance.

Amanda Stevens (Tasmanian Association for Mental Health) told the Committee:

> "I think that age group will be really hard to tap into. We know that. Do we do it through the workplace or do we actually do it through families?

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[164] Trompf, transcript of evidence, 14 November 2005, p. 19
[165] Quinn, transcript of evidence, 10 May 2005, p. 8
[166] Todd and Reid, transcript of evidence, 14 November 2005, p. 4
[167] De Leo, transcript of evidence, 15 November 2005, p. 6
[168] Alomes, transcript of evidence, 10 May 2005, p. 26

> Do we do it with a two-pronged approach and come in through the family and through the workplace? I don't know."[169]

Professor Graham (TSPSC/MHS) said that the approach would need to be different according to a person's circumstances:

> "Again, if you are 25 and married, have employment and are on an income of $80,000 a year, that might require a different strategy than the one applicable if you are living up in the north-west on a farm, isolated from the community and only see your mates once every fortnight."[170]

Status of Present Services and Strategies for Men in Tasmania and Avenues for Development

The Committee took evidence from representatives of two Tasmania NGOs providing programmes specifically for men, namely Tools for Men and Tassie Male. The representatives outlined to the Committee how they access men in need, what approach is taken, and other problems and difficulties that arise.

Some witnesses suggested new avenues for developing suicide prevention services for men, based on existing gaps or the need to find a more effective approach.

The Committee was informed that there were "very few men's programmes around".[171]

[169] Stevens, transcript of evidence, 10 May 2005, p. 12
[170] Graham, Gavin, Papps, transcript of evidence, 20 April 2007, p. 13
[171] Whittle and Lutz, transcript of evidence, 10 May 2005, p. 56

INSERT 3: TOOLS FOR MEN AND TASSIE MALE

Tools for Men
As part of its counselling and family support services, Anglicare has developed a male-specific model for men with relationship problems. The programme engages with men through a conversational approach in preference of counselling to encourage men to open up about their problems.[172]

It is recognised that: Men have their own issues in families and relationships; men have been faced with huge social changes in the last 20 years; most men are committed to their families and relationships; many men do not use existing counselling services; some men prefer to discuss matters with another man; and men often want information and/or advice to solve their problems.[173]

Les Whittle (Anglicare) told the Committee:

"We run workshops, we downgrade, move away from the strict counselling model which is that men will only go to a counsellor when it is a last resort and we all know that counsellors break up marriages because people who go to counselling normally separate. We try to do something that is a little bit different and we have called part of the Tools for Men program 'A Chance to Chat'. A guy might ring through to us and say, 'I have some issues. I need to talk to someone but I do not necessarily want to talk to a counsellor'."[174]

Tassie Male
The Tasmanian division of Relationships Australia, as part of its men and family services, has developed a programme called Tassie Male, which *inter alia* provides counselling and advice for men.

Roseanne Brumby (Relationships Tasmania) said that "a lot" of the clients at Tassie Male have suicidal feelings. She explained further:

"It is a permanent program and the funding for that is oriented towards men in crisis, particularly men who are having problems parenting and having access to their children… Often they are feeling that the system is against them and that the system is not fair. They often have a lot of anger and under the anger there is a lot of grief and despair and a sense of unfairness and a sense, men particularly, that their role as a parent is not acknowledged and is not valued".[175]

Witnesses had a range of propositions to enlarge services for men or to find new means of accessing men, including through schools, workplaces, and pubs.

Ron Chapman (Parakeleo Industries) said workplaces should be pursuing suicide prevention to a greater extent:

[172] Document provided by Anglicare (no. 13)
[173] Document provided by Anglicare (no. 13)
[174] Whittle and Lutz, transcript of evidence, 10 May 2005, p. 52
[175] Brumby, transcript of evidence, 4 August 2005, p. 76

> "One way of doing that is by equipping and empowering people with the information, suicide intervention information, the courses, particularly through workplaces. Of that particular age group, there is a better chance that they are involved in a workplace and so the more that workplaces can embrace suicide intervention, as part of their overall caring for their people, has to make a difference."[176]

Amanda Stevens suggested that pubs could assist their male patrons:

> "Let us use our Neighbourhood Houses or let us offer the licensee of local rural pubs a course in suicide prevention. Obviously these men are going to go to pubs. Why can't we offer bar staff some prevention and assistance training?"[177]

Linda Trompf said that if teenage and young males could be encouraged to acknowledge any problems they might have prior to age 25, "hopefully we can prevent them getting into the chronicity of long-term mental illness and reduce their risk of suicide." Rather than allow problems to develop, a "getting-in-early strategy" would link men to services before they are too old and find it harder to seek help.[178]

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[176] Walker, Chapman [R], Chapman [L], Johnson, Fairbrother, Hite, transcript of evidence, 3 August 2005, p. 36
[177] Stevens, transcript of evidence, 10 May 2005, p. 13
[178] Trompf, transcript of evidence, pp. 18-19

Conclusions

(Chapter 3, Term of Reference 2: The investigation of strategies in relation to the needs of men in Tasmania)

17: Men have difficulty communicating with other people about their personal problems. This compounds the effort to bring assistance to them and to identify men in the community who need help.

18: Some services are available specifically for men in Tasmania, but it is unfortunate that more do not exist.

Recommendations

(Chapter 3, Term of Reference 2: The investigation of strategies in relation to the needs of men in Tasmania)

11: Services that specifically aim to prevent suicide among men should be increased.

12: Men need to be encouraged to seek help if they are enduring emotional and personal problems.

13: Any future suicide prevention strategy (or strategic planning) in Tasmania must seek to address the prevalence of male suicide and male attitudes to approaching personal problems.

CHAPTER 4
Term of Reference 3

DETERMINING THE AVAILABILITY OF DATA COLLECTION RESOURCES AND OPPORTUNITIES FOR RESEARCH TO IDENTIFY STATE SPECIFIC TRENDS

Introduction

Data collection and research into suicide in Australia and particularly Tasmania appears to be generally limited. Data and research that is available can be utilised to ensure more is known about suicide and how it affects people, thereby improving overall effectiveness. It was impressed upon the Committee that more can be done in this area, with the caveat that focus should not be lost on actual prevention work.

The Usefulness of Data in Relation to Suicide Prevention

Witnesses were divided over how useful data could be for suicide prevention. While the Committee heard no evidence to suggest the collection of data was counter-productive, opinions on its usefulness in terms of pursuing suicide prevention ranged from possibly useful to always useful, to providing good guidance to distracting.

Renée Woodhouse (MHS) stated:

> "I think generally research can guide us into what needs to happen and the more data we have and the more Tasmanian-specific data we have… I think the better we will understand the particular circumstances within Tasmania."[179]

Ray Kemp (MHS) was asked whether analysis of emerging statistical trends could be used to predict where programmes should be directed. He replied, "Yes." [180]

Dr Chris Moorhouse (Meander Valley Enterprise Centre) said that even though a great deal of research had been done, "all sorts of recommendations have arisen" that were diverse and inconsistent, which "is a reflection itself of the complexity of the problem."[181]

Linda Trompf (ACT MHS) said:

> "Suicide data is difficult to collect, I think it is something we should be collecting but I don't think it is necessarily the data that we should be using to measure the success or otherwise of our interventions, partly

[179] Kirkby, Bent, and Woodhouse, transcript of evidence, 23 November 2004, p. 14
[180] Kemp, transcript of evidence, 14 June 2005, p. 5
[181] Moorhouse, transcript of evidence, 4 August 2005, p. 61

> because I think it is pretty rubbery data anyway. I think the data that perhaps is useful is the number of admissions to hospital. If we can see those coming down then I think that can tell us whether the programs that we are running are having good outcomes."[182]

In some instances witnesses believed data could be utilised to a greater extent if it were more reliable, but noted that the thoroughness required to acquire such data was simply unrealistic.

Professor Diego de Leo stated:

> "We have been unable so far to provide such research as to really be able to capture a rare phenomenon… that was needed to control if an intervention was by any chance more effective than another. To give you a dimension of the amount required, if you wanted to intervene on the general population level, which includes certainly cases at higher risk, you would need dimensions of 14 million or 15 million people. …Which is unfeasible. Nobody does that."[183]

Jan Murphy (Lifelink) told the Committee that data comes after the fact, and does not directly prevent suicide:

> "No matter how much data you collect it is not going to make an eyeful of difference at the end of the day if somebody wants to take their own life. Stats are all very well but it is just dealing with what has already happened."[184]

Scope, Availability, Reliability, and Sources of Present Data and Research

Basic figures on suicides in Tasmania are available back to about 1978.[185] The Committee heard evidence from government agencies, NGOs, and academics and researchers in relation to the scope, availability, and sources of data and research. The Coronial Office appears to be the only primary source in Tasmania of basic data relating to deaths caused by intentional self-harm. The Coronial Office and Mental Health Services are developing databases on suicide, and improving the functional capacity of these databases. Tasmania Police has started to keep information for operational purposes. Some information known to government agencies is withheld to ensure confidentiality.

Some non-government service providers are keeping basic details of their clients, but have a limited ability to share information due to privacy requirements, and such initiatives may be relatively recent.

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[182] Trompf, transcript of evidence, 14 November 2005, p. 21
[183] De Leo, transcript of evidence, 15 November 2005, p. 2
[184] O'Sullivan, Murphy, and Romenelli, transcript of evidence, 4 August 2005, p. 32
[185] TSPSC *Report 2004/2006* (DHHS, Hobart, 2006) contains some figures that date back to 1978 (document no. 29)

Data collection, overall, was described *inter alia* as poor, although the situation seemed to be improving on the past. With the rise of the Internet, international research has become easier to access.

Databases containing information relating to suicide appear to be increasing both horizontally (in number) and vertically (in detail and depth), compared to the past, which is providing new avenues for quantitative research.

Supporting research activity is the fourth area of activity of the TSPSC. Specifically, this is auditing suicide prevention services, for the purposes of mapping and making information about services available; and utilising the NCIS database. The TSPSC's fifth area of activity is to support an evidence base for the development of programmes and for use in practice by managing and compiling a database with data from the Coroner's Court. According to the TSPSC Annual Report, "Collation and basic analysis is conducted by Mental Health Services."[186]

According to Professor Des Graham (TSPSC/MHS), data collection is "limited" and "poor", although opportunities for improvement are being pursued:

> "We have some data collection through Mental Health Services but it is limited. We have some data collection through the coroners, but the coroners' information is clearly those people who have taken their lives… data collection and information management systems within mental health programs, for example, require significant development and we are, as a business unit of the Department of Health and Human Services, having internal conversations with our infrastructure and our information people about how we collect that data better. … Overall, there is poor data collection."[187]

Wendy Quinn stated that information on suicides is usually out of date:

> "The information in relation to suicides, when you are using accessing information from the Australian Bureau of Statistics, is always a number of years out of date because of the lengthy period of waiting for inquest processes and confirmation."[188]

Ray Kemp (Project Manager, Information and Evaluation Unit MHS, which supplies the TSPSC with its information), explained to the Committee how data is sourced and what is available:

> "The statistics we utilise are provided by the Coroner's Court. So we are reliant on the coroner making the determinations and therefore the information provided to us we record into a basic database system from which we provide updates and analysis… One of the areas that most people are particularly interested in which is causality of suicides, there is no information directly being collated and put together. It is a very

[186] TSPSC *Report 2004/2006* (DHHS, Hobart, 2006), pp. 21-23 (document no. 29)
[187] Graham, Gavin, Papps, transcript of evidence, 20 April 2007, p. 15
[188] Quinn, transcript of evidence, 10 May 2005, p. 2

> complex area to try to work out the causes and, from what I understand; the coroner does not directly attribute causes. All he does is identify whether the person took their own life or the death is from other causes.[189]
> …
> At the moment it is really some fairly basic information about who they are, their age, place of death and the method of suicide. So there is a limited range of information that is currently available. Also, we have limitations on how we can utilise this information. We do not go into small areas because we could then start to get into breaches of confidentiality – once you get down to small counts, people can be identified."[190]

Jim Connolly (Coroner's Court) told the Committee that Coronial data was now electronically stored, which allows for the efficient retrieval of information and contribution to a national database:

> "Almost five years ago now we implemented a new coronial case management system, an IT system, in Tasmania which has an interface and uploads data into the National Coroners Information System. … It is a relatively new development. It is the first one in the world where there is a single database of all coronial cases that is accessible electronically. It is used as a research tool by coroners, pathologists, injury and death prevention organisations, anyone from motor vehicle manufacturers associations to the Royal Surf Lifesaving Association. …Both the national one and the Tasmanian one that I mentioned that we implemented can now be electronically searched".[191]

The Coroner's Court provided the Committee with a police report of death form. This form shows that police gather detailed information about a person's death, which would include cases of suicide, that is passed on to the coroner. The form has space for information relating to a person's details, which include: basic personal details, such as name and age; marital status; usual occupation and employment status; ethnicity; medical information, including mental health; criminal history; time spent in a custodial environment; location of death; activity at the time of the incident; and the apparent actual cause/s of death.

The form has spaces for specific information related to the circumstances of the death (that could relate to suicide method). The specific sections include: work; firearms; fire or burn; transport; suicides (reproduced below); suspected drugs, alcohol, or poisons; drowning or water; and unexpected infant death.

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[189] Kemp, transcript of evidence, 14 June 2005, p. 1
[190] Kemp, transcript of evidence, 14 June 2005, p. 2
[191] Connolly and Scott, transcript of evidence, 10 May 2005, p. 19

Police report of death form, suicide section

Section 13 – SUSPECTED SUICIDE

What evidence is there to indicate that the deceased intended suicide? *(tick the relevant box(es))*

☐ Statement to Family/Friends ☐ Statement to Health Professional
☐ Note / Letter ☐ Other *(specify)*:

Has the deceased previously attempted suicide? ☐ No ☐ Yes ☐ Unknown

If 'YES' , approx number of times:

Has the deceased previously been hospitalised for self harm? ☐ No ☐ Yes ☐ Unknown

If 'YES' , approx number of times:

Is there any possible motive / trigger for the suicide? (tick the relevant box(es))

☐ Relationship Breakdown ☐ Sexual Abuse ☐ Financial Problems
☐ Loss of a Loved One ☐ Illness ☐ Prospect of Criminal Sanction
☐ Alcohol / Drug Dependency ☐ Unknown ☐ Other *(specify)*

Was deceased being treated / seen by any of the following professionals? (tick relevant box(es))

☐ General Practitioner ☐ Psychiatrist ☐ Psychologist ☐ Case Manager

Was the death accompanied by the murder / suicide of other person(s)? ☐ No ☐ Yes

If 'YES' , what was the relationship between the deceased and the person(s)?

Source: Coroner's Office, Hobart (document 34)

Ray Kemp (Information and Evaluation Unit, MHS) said:

> "If this coroner's database actually develops what we do may be redundant. We may actually rely on that coroner's database if we can access it and if it is maintained as an up-to-date process. That would give us then the potential to look at what happens in other States, make those comparisons and look at Australia on a broader scale."[192]

Some witnesses told the Committee that the reliability of available data could be compromised by variables beyond the control of data collectors, for reasons such as under-reporting and accidents that could plausibly be suicide.

Professor Graham said suicide was under-reported:

> "In terms of the number of people who attempt suicide or suicides which are under-reported – and we know that suicide is under-reported – there is really limited data collection in those areas."[193]

Linda Trompf said accidents and suicides could be potentially counted together:

> "In the ACT – and I am sure it is the same in Tasmania and other jurisdictions – a suicide is only confirmed as a suicide once you have had the coronial inquiry. They are the only ones that are counted, which would seem to me that we are missing a lot. There would be a lot

[192] Kemp, transcript of evidence, 14 June 2005, pp. 13-14
[193] Graham, Gavin, Papps, transcript of evidence, 20 April 2007, p. 15

> happening that we are not counting, but it is also difficult to know how you count those. Who is going to go back and ask whether the guy who ran off the road and hit a tree was an accident or a suicide?"[194]

The Committee asked Ray Kemp what degree of certainty existed in suicide statistics, in terms of accidents that could be suicides and *vice-versa* that could alter the total of suicides. He assured the Committee this is not a significant problem:

> "I do not think there is a high level of uncertainty… we are provided with deaths that are potential suicides which we use to record in our system and over a period of time as the coroner makes a determination – sometimes up to two to three years after the fact – we go through and actually clean out those. Eventually, over a period we end up with those who are purely determined as suicides by the coroner."[195]

Tim Johnstone (Project Positive) explained that suicide statistics can get "screwed up" depending on where a person is found deceased.[196] A person may choose to leave home, and concentrations of suicides in cities or regions may inflate the perceived risk of communities:

> "There is some anecdotal stuff to say that the north-west coast suicide rate has increased as a result of putting [the] *Spirits* on, because people who are running away from a problem in Melbourne or Sydney are coming to Tasmania and then killing themselves just outside Devonport."[197]

He also said that as a number of people are sent to Hobart, from elsewhere, for the treatment of mental health problems (which might not be properly treated), this could inflate the city's suicide rate:

> "Hobart will have a higher ratio because people are sent down there for mental health issues and mental health issues are not adequately dealt with, but that doesn't mean Hobart is going to have a higher suicide rate than the north; it just means they are down there."[198]

Due to ethical considerations, the Committee was told, not all information can be released publicly and some studies and research cannot be approved.

Jim Connolly said that the details of coronial inquiries are not always published or made public:

> "We do not think it is appropriate, for example, in a lot of, say, the suicide deaths to publish those because that is traumatic for the family and friends. … It is definitely all captured in the database… we do take our responsibility pretty seriously about taking into account the views of family and friends of the deceased. It is obviously a very traumatic

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[194] Trompf, transcript of evidence, 14 November 2005, p. 21
[195] Kemp, transcript of evidence, 14 June 2005, p. 2
[196] Johnstone, transcript of evidence, 4 August 2005, p. 53
[197] Johnstone, transcript of evidence, 4 August 2005, p. 53
[198] Johnstone, transcript of evidence, 4 August 2005, p. 53

> experience for anyone to go through, and to have details published in some public forum can be very disturbing to some people."[199]

Professor de Leo said that "ethical implications" is one reason why suicide research is "so laid back".[200] He further added that almost all research into suicide is conducted within the United States or United Kingdom:

> "Nearly 100 percent of research is done in two countries – the United States and the UK. The United States does two-thirds and the UK does the remaining third. This means that we know very little from other countries, including Australia, which has not produced much research into suicide. Australia is not the same as the United States, which means that you cannot transplant American projects directly to Australia. You need your local projects because your community is different. You cannot implement a British strategy in India or China… Despite this principle, it is widely accepted that there is always reluctance to fund research locally. The money available is limited because there are other priorities… My personal opinion is that we are far from being considered serious in suicide prevention. If your question is how much research has been done in this domain here, it is very little."[201]

Some representatives of NGOs said that for internal research purposes, they collected limited information on their clients or callers. The information acquired, however, is usually of a general nature to avoid breaches of confidentiality, and for the same reason cannot be shared with agencies or other organisations.

Constance Alomes said Lifeline keeps basic data on callers, which is then collated and subsequently the original data sheets are "shredded".[202]

Lifeline was able to provide the Committee with some generic data about the nature of the calls it receives at its Hobart centre. The data shows that people often call with a variety of issues and suicide may be one issue among others a caller wishes to discuss.

Lifeline Hobart received 4,275 calls seeking counselling from 1 July 2006 to 30 June 2007 out of a total of 5,357. (The other calls were *inter alia* wrong numbers, hoaxes and pranks, people who hung up immediately, and some to express thanks and appreciation.) 350 calls (8.2%) were deemed to be suicide related. Among the 350 calls generally related to suicide, callers may have had multiple issues to discuss about suicide. These callers most commonly had current suicide thoughts (276/78.86%), and some had a suicide plan (120/34.29%) or acknowledged prior suicidal behaviour (111/31.71%). Again, callers may have been in multiple situations, but nonetheless aloneness, illness, mental illness, and relationships and family were common themes. What is clear from the data provided is that most

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[199] Connolly and Scott, transcript of evidence, 10 May 2005, p. 20
[200] De Leo, transcript of evidence, 15 November 2005, p. 15
[201] De Leo, transcript of evidence, 15 November 2005, p. 21
[202] Alomes, transcript of evidence, 10 May 2005, pp. 29-30

people seeking counselling from Lifeline Hobart do not express (or will not disclose), any problems linked to suicide.[203]

A representative of Relationships Tasmania said that statistics were kept on the demographics of clients:

> "We have an excellent database that we have developed specifically for our work. There are years and years of data sitting there, talking about who are clients are, what the success rates are, what the issues are, what the demographics are."[204]

Unknown or Contentious State Specific Trends

During its inquiry, the Committee was made aware that certain perceptions of suicide trends in Tasmania exist, and some witnesses sought to highlight the existence of rumours – in particular a public perception that people regularly jump from the Tasman Bridge.

Ray Kemp said there were some "severely incorrect" myths about suicide circulating, including in relation to the Tasman Bridge:

> "There is a certain amount of urban mythology about suicide. Ask anyone on the street and they will say, 'Yes, one person a week jumps off the bridge'."[205]

Jenny Scott (Coroner's Office) stated that in actual fact, 32 people had jumped since 1982, and:

> "Another myth is that it will be successful, but earlier this year someone did actually survive from the jump".[206]

She also added that a death caused by jumping from the Tasman Bridge in a small number of cases might be considered a drowning rather than suicide, depending on the findings of the pathologist.[207]

Ray Kemp also said that suicides involving Mental Health patients tended to attract attention and become "well-known":

> "It becomes an issue and people feel that there are a lot of suicides happening in Mental Health or with Mental Health patients."[208]

He said that people known to Mental Health Services comprise about 10 to 15 percent of all suicides:

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[203] Document (no. 35) provided by Lifeline Hobart
[204] Brumby, transcript of evidence, 4 August 2005, p. 78
[205] Kemp, transcript of evidence, 14 June 2005, p. 2
[206] Connolly and Scott, transcript of evidence, 10 May 2005, p. 23
[207] Connolly and Scott, transcript of evidence, 10 May 2005, p. 23
[208] Kemp, transcript of evidence, 14 June 2005, p. 10

> "From what we understand, there are a lot of undiagnosed mental health issues with people who suicide. In the past we have identified from those who have a completed suicide those who have a known mental health issue background in that they are known to Mental Health Services, and it is generally around 10 to 15 percent."[209]

Professor de Leo speculated that there might be a "tradition" of suicide in Tasmania, which could account for an above-national average rate as the "frequency of the event feeds further frequency":

> "One factor that should not be neglected, is that in a place where there is a high number of suicides, there is the tendency for the suicide rate to remain high in that place because it is a tradition, so there is the acceptance of the fact or even the pushing towards a certain behaviour. … In every country of the world there are these places. We normally define them as places with a tradition of suicide, which means that this is a habit, which is accepted. 'If I was in those circumstances I would commit suicide because this was done by my father and my uncle' or my grandfather and 'other people that I respect and they had a reputation and nothing happened' et cetera, and this perpetuates the behaviour. … Probably this is a component in the higher rates of suicide in Queensland and in Tasmania."[210]

Opportunities for Research

Several witnesses, when questioned, identified numerous opportunities for further research. Some of the options suggested, however, appear to be without adequate consideration of cost and ethics.

In summary, questions put forward for research included: whether or not there is a moving cohort among the male population, and if so, why it is the case; the timeframe between a person planning their suicide and making an attempt; the impact of early childhood development; the effect of isolation; the number of accidents that were plausibly suicides, and *vice-versa*; asking people who have attempted suicide to participate in a study; a community survey; and study of suicide approached from a point of view other than medical sciences.

Martin Harris told the Committee that there should be "more investigation" into why males from generation "X" are over-represented in suicide statistics, and whether a cohort effect is moving through the community.[211] Generation "X" suicide trends were described by another witness as being "an opening for a lot of research."[212]

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[209] Kemp, transcript of evidence, 14 June 2005, p. 10
[210] De Leo, transcript of evidence, 15 November 2005, pp. 22-23
[211] Harris, transcript of evidence, 4 August 2005, p. 13
[212] Kemp, transcript of evidence, 14 June 2005, p. 4

Ray Kemp said that there was evidence that "a number of people" tend to plan ahead if they are contemplating suicide, and "this is a whole area that needs a lot of research."[213]

Lyn Chapman (Parakeleo) said that a "lot more" research could be done, including looking at how early childhood development impacts on a person's suicide risk later in life.[214]

Dr Chris Moorhouse (Meander Valley Enterprise Centre) agreed the first three years of their life could impact on long-term outcomes. He stated:

> "There has been relatively little attention to those childhood years of thought and behaviour patterns that may ultimately lead to suicide or suicidal ideation."[215]

Dr Moorhouse said that people who have attempted suicide could be asked to participate in a study, in particular to examine how they developed as young people:

> "I think that people who have attempted suicide could give a great deal of insight into what their thought and life experience patterns as young people were. … The trouble is there are lots and lots of case studies in respect of successful suicide, but how the thought patterns arose and what the individual's experiences were are much more difficult things to aggregate. It is my understanding and my belief that, although a great deal of research has been and is being done from around about late teen years when the problem becomes quite severe, I think that there has been relatively little attention to those childhood years of thought and behaviour patterns that may ultimately lead to suicide or suicidal ideation."[216]

Martin Harris said that it might be useful to study how people behave in Antarctica during long winter stints, to observe how people handle isolation over a period of time.[217]

Professor de Leo proposed conducting a detailed community survey to measure the effectiveness of strategies:

> "Imagine that some of you are claiming that the strategy was effective, so let us measure this information in a controlled environment. We have interventions for the elderly, for indigenous people, for youth, for gays and lesbians, for the unemployed… All this kind of information is concentrated in a controlled community. Then look outside at another community that is free from intervention unless already in operation. Then, after one year or two, you see if there are differences in terms of completed suicide, attempted suicide and suicide ideation in the

[213] Kemp, transcript of evidence, 14 June 2005, p. 9
[214] Walker, Chapman [R], Chapman [L], Johnson, Fairbrother, Hite, transcript of evidence, 3 August 2005, pp. 37-38
[215] Moorhouse, transcript of evidence, 4 August 2005, p. 62
[216] Moorhouse, transcript of evidence, 4 August 2005, p. 62
[217] Harris, transcript of evidence, 4 August 2005, pp. 8-9

> population. How can you do that? Through a community survey. The cost of this operation was $1.7 million for two communities of 260,000 inhabitants, so that is not an unbearable cost if you consider that we are investing $10 million per year in suicide prevention."[218]

Professor de Leo as said that most researchers into suicide come from a medical background, which could cause some "distortion" because research comes from a psychiatric point of view only:

> "All other results will be undetectable to you, simply because we are ignorant in other fields. Even if there were striking evidences coming from the social, anthropological, cultural or whatever other environments, we were unequipped to clearly pick up these scenarios."[219]

[218] De Leo, transcript of evidence, 15 November 2005, p. 19
[219] De Leo, transcript of evidence, 15 November 2005, p. 1

Conclusions

(Chapter 4, Term of Reference 3: Determining the availability of data collection resources and opportunities for research to identify state specific trends)

19: While the amount of research and data collection on suicide in Tasmania may be less than ideal, it nevertheless serves an indirect role in suicide prevention. Increased knowledge about suicide allows for more effective prevention.

20: The Coroner's Office is the primary source of information on deaths in Tasmania, and this information is further analysed by other government agencies and researchers. Non-government organisations may choose to collect some information about their clients.

21: For various reasons, not all the data that is collected on suicides in Tasmania is necessarily made available to the public, although the TSPSC could include more quantitative data in its annual reports than it presently does.

Recommendations

(Chapter 4, Term of Reference 3: Determining the availability of data collection resources and opportunities for research to identify state specific trends)

14: More research into suicide in Tasmania, whether funded by government or non-government sources, would be useful, though it should not be excessive and overshadow actual suicide prevention activities.

15: Funding should be specifically provided for research into suicide and periodic analysis of suicide data in Tasmania, which should be conducted by a body independent of the TSPSC that would provide an alternative Tasmanian-based source of research and data analysis. The TSPSC could continue to produce its own research and data analysis.

16: Tasmania should work to achieve greater consistency of data collection across all jurisdictions in order to enhance data collection capabilities to improve research into suicide prevention.

Parliament House
Hobart
15 November, 2007

The Hon. K. Finch MLC
CHAIRMAN

APPENDIX 1: Modification to the Terms of Reference

The Committee modified its terms of reference on 12 June 2007. The original terms of reference were as follows:

The Committee will examine the effectiveness of current national and local strategies in addressing the issue of suicide and suicide prevention in Tasmania in a range of settings with particular attention to:

1. The role of non-government organisations, and other community and business partners in progressing suicide prevention in Tasmania

2. Strategies to address the needs of men aged 25-44

3. Determining the availability of data collection resources and opportunities for research to identify state specific trends

4. The role of the media in suicide prevention

5. Opportunities in the workplace to promote wellness and suicide prevention

6. Any other relevant matters

APPENDIX 2: Submissions Received

Public notices were placed requesting written submissions by 16 May 2005. In total, 20 written submissions were received.

Number	Name/Organisation/Body
1	Sheree Edwards
2	CORES – Ron Chapman and Coralanne Walker
3	Anne Bevan
4	Pindari Herb Farm – Ken Atherton
5	Shirley Green
6	Brenda Gray
7	Tasmanians with Disabilities – Robin Wilkinson
8	Christopher Pyne – Parliamentary Secretary to the Commonwealth Minister for Health and Ageing
9	Youth and Family Focus – Wayne Gaffney
10	GROW Tasmania – Sheryl Rainbird
11	Lindsay Smith
12	Lifelink Samaritans – Jan Murphy, Luigi Romanelli, Peter O'Sullivan
13	ARAFMI – Kerryal Willis
14	Parakaleo – Ron Chapman
15	TasCOSS – Mat Rowell
16	Brain Injury Assoc – Deborah Byrne
17	Jane Chapman, Sally Coker, and Mark Brown
18	Jane Chapman, Sally Coker, and Mark Brown
19	Dawn Chiller
20	"wkashley"

APPENDIX 3: Witnesses

The Committee had an initial recorded briefing from representatives of the Department of Health and Human Services and one representative from the University of Tasmania on 23 November 2004 under the agenda title of “Early Intervention into the Prevention of Suicide”.

Public hearings for the inquiry were held mostly during 2005, on 10 May in Hobart, 14 June in Hobart, 3 August in Devonport, 4 August in Launceston, 20 September in Hobart, 18 October in Hobart, 8 November in Hobart, and 20 April 2007 in Hobart. During November 2005, the Committee travelled interstate and held discussions in Canberra on November 14 and Brisbane on November 15.

In total, 47 witnesses gave verbal evidence.

Dates	Witnesses
23 November 2004	Prof. Ken Kirkby, (UTAS), Mary Bent (Dep Sec, DHHS), and Renée Woodhouse (DHHS)
10 May 2005	Wendy Quinn (DHHS) Amanda Stevens (Tasmanian Association for Mental Health) Jim Connolly (Administrator of Courts) and Jenny Scott (Magistrates Court Clerk) Constance Alomes (Lifeline Hobart) Dave Willans (YNOT) Helen Barrett (Dept of Education) Les Whittle (Anglicare), Angela Lutz Mat Rowell (TasCOSS)
14 June 2005	Ray Kemp (Mental Health Services, DHHS)
3 August 2005	Wayne Gaffney (Youth and Family Focus) Sheree Edwards Coralanne Walker (Kentish Health Centre), Ron Chapman (Parakeleo Ministries), Cheryl Johnson (Careworks), Royce Fairbrother (Fairbrother Constructions), Paul Hite (Parakeleo), and Lyn Chapman (Parakeleo)

	Irene Harding and Justine Barwick (Carelink)
4 August 2005	Martin Harris (Rural Health, UTAS) Peter O'Sullivan, Jan Murphy, and Luigi Romanelli (Lifelink Samaritans) Tim Johnstone (Project Positive) Dr Chris Moorhouse (Meander Valley Enterprise Centre) Shirley Green Roseanne Brumby (Relationships Tasmania) Liz Gee, Nigel McLaren, and Jennifer Stanton (Time-Out) Jane Chapman and Sally Coker
20 September 2005	Jack Herman (Australian Press Council) Garry Bailey (the *Mercury*)
18 October 2005	Scott Tilyard (Tasmania Police)
8 November 2005	Dr Ashley Ashley (RHH)
14 November 2005	Keith Todd (Ozhelp) and Irmgard Reid (VYNE) Linda Trompf (ACT Mental Health Services)
15 November 2005	Prof. Diego De Leo (Griffith University/Australian Institute for Suicide Research and Prevention)
20 April 2007	Des Graham (Mental Health Services/TSPSC), Robert Gavin (MHS), and Janette Papps (MHS)

APPENDIX 4: Documents Taken Into Evidence

Title/Description	Author/Source	Document Date	Document Number
LIFE – Living is for Everyone: A Framework for Prevention of Suicide and Self-ham in Australia: Building Partnerships	Commonwealth Dept of Aged Care and Health	2000	1
Tasmanian State Government Suicide Prevention Activity	DHHS	July 2004	2
Tasmanian Suicide Prevention Steering Committee Annual Report, 2001-2002	Mental Health Services, DHHS	2002	3
World Suicide Prevention Day, information sheet	Suicide Prevention Australia	2004	4
Beyond Blue (package of documents)	Beyond Blue	2004	5
Suicide Prevention in Tasmania: An Overview	DHHS	November 2004	6
Mental Illness: Facts and Statistics	MindframeMedia.info	Undated	7a
Suicide: Facts and Statistics	MindframeMedia.info	Undated	7b
Tasmanian Community Bereavement Support Kit	Tasmanian Community Bereavement Support Project, Tasmanian Assoc for Mental Health	Undated	8
Tasmanian Suicide Prevention Steering Committee Report, 2002-2004	DHHS	2005	9
NCIS pamphlet	Coroner's Office	Undated	10
Terms of Reference for the Tasmanian Youth Suicide Prevention Forum, September 2000	Youth Network of Tasmania	2000	11
Mind Matters pamphlets	Mind Matters, Commonwealth Dept of Health and Ageing	April 2005	12
RE: Tools for Men	Anglicare	May 2005	13
Information from Kentish Health Centre Tandara Lodge and Parakeleo	Parakeleo/Kentish Health Centre	Undated	14a
Suicide Intervention Initiative	Parakeleo	Undated	14b
Letter from Martin Harris	Martin Harris	August 2005	15
Lifelink Samaritans information package	Lifelink	Undated	16
POSITIVE pamphlets	POSTIVE	Undated	17
Time-Out information sheets	Time-Out	Undated	18
Reporting of Suicide	Australian Press Council	Undated	19
Letter from Lifelink	Lifelink	October 2005	20
CISM pamphlet	Tasmanian Emergency	Undated	21

	Services		
Dept of Psychological Medicine forms	Dept of Psychological Medicine, RHH	Undated	22
Ozhelp information pachage	Ozhelp	2005	23
VYNE Calendar of Events	Calvary Health Care ACT, ACT Health	2005	24
Managing the Risk of Suicide 2005-2008: A Suicide Prevention Strategy for the ACT	ACT Health	Undated	25
Documents on workplace health	Various	Undated	26
Paths of Healing: Information for Consumers and Carers	ACT Health	Undated	27a
ACT Health various pamphlets	ACT Health	Undated	27b
Health Action Plan 2002	ACT Health	2002	27c
MOU and Working Protocols Between Tasmania Police and DHHS	Tasmania Police, DHHS	December 2000	28
Tasmanian Suicide Prevention Steering Committee Report 2004-2006	DHHS	2006	29
Suicide in Queensland 2002-2004: Mortality Rates and Related Data	Diego de Leo, Helen Klieve, and Allison Milner	2006	30
National Suicide Prevention Strategy project funding allocations 2006-2008	Commonwealth Dept of Health and Ageing, Tasmanian Office	2006	31
Letter from Southern Cross Television	Grant Wilson	August 2007	32
Letter from WIN Television	Greg Rayment	August 2007	33
Police Report of Death for the Coroner form	Coroner's Office	Undated	34
Lifeline Hobart call reports statistics 2006-2007 spreadsheets	Constance Alomes	September 2007	35
Letter and enclosed spreadsheet	DHHS (Mental Health Services)	October 2007	36
'Suicides, Australia, 2005', 3309.0	Australian Bureau of Statistics	March 2007	37
'Suicides, Australia (1921-1998)', 3309.0	Australian Bureau of Statistics	Undated	38
International Suicide Rates: Recent Trends and Implications for Australia	Diego de Leo and Russell Evans	2003	39
APC General Press Release no. 246 (i), 'Reporting of Suicide'	Australian Press Council	July 2001	40
Commercial Television Industry Code of Practice	Free TV Australia	July 2004	41