The Royal Australian & New Zealand College of Psychiatrists

Inquiry into Youth Suicide Prevention

Submission to the House of Representatives Standing Committee on Health and Ageing – April 2010

working with the community

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Executive Summary

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) is committed to improving the outcomes of people who may have attempted or who are at risk of suicide. Addressing the incidence of suicide in Australia requires strategies to address the factors that contribute to and perpetuate suicide. There is consistent evidence to support the finding that people who die by suicide have a much higher prevalence of mental illness than the general population. Prevention and early intervention of mental illness in childhood and adolescence is therefore particularly important

Statistics regarding suicide rates in Australia dispel the widely held belief that there is a "youth suicide epidemic". Suicide rates among young males have fallen considerably over recent years (by about 50% since 1997) and between 1998 and 2005 the highest rates have been observed for males aged in the 25-45 year age groups [1]. The number of suicides among older age groups can also be expected to rise, given that they constitute the fastest growing segment of the population. This demonstrates that youth suicide prevention, although important, is one aspect only. The current National Suicide Prevention Strategy covers all ages and the RANZCP supports the continuation of suicide prevention strategies that cover all age groups. The Australian Suicide Prevention Advisory Council is currently undertaking a variety of initiatives in regard to suicide prevention, and youth suicide prevention strategies should be addressed and considered concurrently with this work.

In November 2009 the RANZCP made a submission to the Senate Community Affairs References Committee in response to its Inquiry into Suicide in Australia. This submission seeks, in line with the terms of reference, to focus on issues pertinent to youth suicide. However, the key priorities for attention in suicide prevention, particularly as they relate to mental illness, are the same regardless of age group and require:

- Improved service availability, accessibility and navigability for those most at risk
- Suicide prevention research programs to be coordinated and integrated at the highest level with strategic leadership to ensure effective outcomes
- Improved community and practitioner mental health literacy through the use of education programs aimed at identification of, and support for, those at suicide risk
- Increased resourcing and programs in early identification and intervention
- Development of a cross sector suicide reporting system that is easy to use and allows accurate data reporting
- Reduction of access to means of suicide

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1. About the RANZCP

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) is the principal organisation representing the medical specialty of psychiatry in Australia and New Zealand and has responsibility for the training, examining and awarding the qualification of Fellowship to medical practitioners. There are approximately 3000 Fellows of the RANZCP who account for approximately eighty-five per cent of all practicing psychiatrists in Australia and over fifty per cent of psychiatrists in New Zealand. There are branches of the RANZCP in each state of Australia, the ACT and New Zealand.

Through its various structures, the RANZCP accredits training programs and administers the examination process for qualification as a consultant psychiatrist; supports continuing medical education activities at a regional level; holds an annual scientific congress and various sectional conferences throughout the year; publishes a range of journals, statements and other policy documents; and liaises with government, allied professionals and community groups in the interests of psychiatrists, patients and the general community.

The RANZCP is a leader amongst Australasian medical colleges in developing partnerships with consumers and family and other carers in respect to excellence of service provision. The Board of Practice and Partnerships includes consumer and carer representatives from a variety of backgrounds who contribute extensively to the development and management of RANZCP programs and activities, and works together with the community to promote mental health, reduce the impact of mental illness on families, improve care options and supports, and ensures that the rights of people with mental health concerns are heard by mental health professionals. The RANZCP has a Faculty of Child and Adolescent Psychiatry whose expertise has been used in the development of this submission.

2. About Youth Suicide and Mental Illness

Suicide is a leading cause of death for people around the world, greatly impacting families, friends, workplaces and communities. Suicide has biological, cultural, social and psychological risk factors. The connection between mental disorders and suicide is particularly strong. Serious mental illness such as depression, substance abuse, anxiety disorders and schizophrenia are strongly associated with increased risk of suicide. The RANZCP recognises that it is devastating for families to lose anyone to suicide and psychiatrists are committed to reducing this death toll by providing best available psychiatric care.

For youth aged 15-24 years, suicide accounts for 20% of all deaths [2]. Crucial to suicide prevention in youth is the prevention and early intervention of mental illness in childhood and adolescence. The Child and Adolescent component of the Australian National Survey of Mental Health and Wellbeing reported in 2000, that 14% of children and adolescents (14 – 17 years) experience mental health problems [3]. This proportion also correlates to other studies internationally [4]. The national survey also reported that that adolescents with mental health problems report a high rate of suicidal thoughts and that 12% of 13-17 year olds reported having thought about suicide, while 4.2% had actually made a suicide attempt.

Mental illness in infancy, childhood or adolescence can have enduring consequences if left unresolved. Those affected bear a major burden in suffering, lost opportunities and reduced social and economic outcomes in adulthood. Among the many adverse outcomes are reduced self-esteem or confidence, reduced educational and occupational opportunity, increased risk of substance abuse and other mental disorders, as well as increased family conflict, family breakdown and homelessness. There is also a higher prevalence of child and adolescent mental health problems among those living in low-income, step/blended and/or sole-parent families, and a low weekly household income was also shown to more than double the risk of mental health problems. These factors contribute to an increased risk of suicide.

Worryingly, only one out of every four young persons with mental health problems receive professional health care [3]. Even among young people with the most severe mental health problems, only 50% receive professional help with parents reporting that help was too expensive or they didn't know where to get it, and that they thought they could manage on their own. Improved mental health literacy, matched by improved accessibility to mental health services and collaborative initiatives that encourage a reduction in stigma and an increase in help-seeking, remain central to minimising the risk of suicide and self-harm among young individuals. Adequate consideration should be given to suicide attempts and this should specifically target those at elevated risk [5]. Some of these interventions need to be clinically-oriented, and should involve ensuring that clinicians are able to detect, diagnose, assess and manage suicidal risk. Other interventions should be population-based and should draw on sectors outside health to reduce known risk factors [5].

Psychiatrists have a critical role in overseeing the issues that surround advice on suicide; both in the education of other professions about mental illness including identifying risk factors that may lead to suicide, and in monitoring and advocating for service responsibility and improvement. However, as suicide is linked to a broad range of psychological and social factors, psychiatrists and other mental health professionals may not always be placed to advise or offer assistance to prevent suicide in youth. This highlights the need for general improvement of mental health literacy for all practitioners, agencies, and community groups in identifying the risk factors, and carrying out further action as appropriate.

3. Key priorities

The RANZCP recognises and commends the work that the Australian Government has undertaken in regard to the National Suicide Prevention Strategy. The Living Is For Everyone (LIFE) Framework developed under the National Suicide Prevention Strategy includes a range of strategies which the RANZCP fully supports. In this response the RANZCP focuses on the development of specific strategies to advance the issues unique to youth mental illness and its association with suicidal behaviours which it believes will enhance the work already being undertaken in this area.

3.1 Improved services for those at risk

There is a need for improved health service availability, accessibility and navigability for those who require mental health support with a focus on reducing associated stigma.

There is a need for better coordination of the activities of the National Mental Health Strategy and the National Suicide Prevention Strategy to help achieve the aim of channelling more people with mental disorders and suicidal behaviours into appropriate treatment [6]. For adolescents this requires age and culturally appropriate services that focus on treatment and support options, and involve a range of health practitioners, youth mental health workers, and other relevant community supports that are beneficial for consumers, carers and their families.

The Australian Government's investment over the last few years has provided a significant boost to the mental health system, however the RANZCP believes that the overall investment in the mental health service system, including suicide prevention services, remains inadequate and does not reflect the burden of disease in the community. A significant increase in funding to the mental health sector is required so that available resources are proportionate to the increasing number of people with mental illness.

To help prevent youth suicide, further investment must be made in the prevention, identification and appropriate treatment of mental illness for people in Australia including increased and improved workforce, research, consumer involvement, and funding. Services should be accessible and easy to navigate. If young people attend an agency that may not service their needs directly, they must be able to receive guidance regarding engaging with a service that can assist.

There is a need to raise awareness about the personal and financial costs of untreated mental illness in adolescence, particularly as this relates to suicide. Affected youth, and their parents, often delay in presenting symptoms for professional assessment. This delay in assessment could potentially be addressed through greater public awareness of symptom expression and reduction of stigma associated with such concerns, greater coordination and communication between heath care and educational services, and by reducing practical barriers to accessing services.

Improved service availability and accessibility, as well as improved services to adequately deal with youth mental illness and suicide risk, requires:

- Adequate funding for Child and Adolescent Mental Health Services that is relative to the proportion of the population experiencing disorders
- Increased capacity and competence of the workforce to engage in prevention and early intervention work

- Coordinated and integrated care between health and other sectors to deliver prevention and early intervention programs to target high-risk groups
- Continued strategies to reduce stigma associated with mental illness in children and adolescents

Particular strategies and services should be developed and enhanced for those most at risk, in particularly people who self-harm, suicide attempt survivors, and adolescents suffering from depression.

3.1.1 Youth who self-harm and suicide attempt survivors

Suicide rates rise through the teen years and into the 20s. The Australian Bureau of Statistics does not routinely report suicide rates for those under 15 years of age, but tragically, while rare, such deaths do occur even in the very young. In Australia, the suicide rate for those under 15 in the period 1990-1999 was 0.23 per 100,000 [7]. For youth aged 15-24 years, suicide accounts for 20% of all deaths [2]. Suicide risk factors and processes often extend back to early childhood. Psychological, biological, and illness-related factors interact with family, school and wider socio-cultural environments. Specific suicide prevention strategies are required for adolescents, including for suicide attempters. Further research into these strategies is required to ensure that they are effective and that they can be readily used in a broad range of settings.

For adolescent suicide prevention, there are a range of programs which may be worth considering:

- School-based programs are important and can include suicide awareness, skills training, screening, peer support and gatekeeper training, although there is a mixed level of evidence about the effectiveness of these programs [8]. Gatekeeper training is likely to be the most effective and teachers particularly are in a good position to recognise early indicators
- Using a combination of universal approaches to improving mental health and promoting help-seeking behaviour, and selected and indicated programs (e.g. screening, case-finding and anti-bullying referral programs) is most likely to be effective
- The use of Reach Out http://au.reachout.com/ and *beyondblue* websites http://www.youthbeyondblue.com/ may be helpful although there is no evidence that they prevent suicide

Adolescent suicide attempters are another high risk group that require specific attention. A study to assess the feasibility of systematically treating depressed adolescents who had recently attempted suicide demonstrated that allocation to Cognitive Behavioural Therapy, medication, or the combination of both lowers the 6-month risk for suicide events and reattempts [9]. Further research and evaluation in this area is necessary

Suicide attempt survivors are often misunderstood, isolated and neglected. Engagement, follow-up and maintaining contact with suicide attempt survivors after emergency room contact is critical. Positive results have emerged from recent studies showing that maintaining contact with suicide attempt survivors or those who self-harm after discharge can significantly reduce their risk of subsequent attempts and death [26-28]. Continuing support can be as simple as sending people postcards or letters [26, 27] at least four or five times a year, which has demonstrated effectiveness. More recently an international WHO study [28] has shown that a dual intervention of a one-hour information session, referral options and follow-up contacts (phone or in person) over a period of 18 months is effective. It

was also suggested that when contact was reduced or ceased, the preventative effect also disappeared [27].

These successful interventions are relatively inexpensive and work through enhancing social connection and sense of personal value. Allowing for appropriate cultural and age adaptation, these programs deserve widespread further research and implementation in local settings.

***Recommendation**:*

1 Assistance should be provided to suicide attempt survivors, and those who self-harm, by offering post-discharge support. This must include funding and support for interventions that maintain contact and follow-up after the event

3.1.2 Youth depression

Youth depression is significant in regard to suicide risk. Studies show one-year prevalence rates are about 2% in childhood and range from 4% to 7% in adolescence and the lifetime prevalence in adolescents aged 15 to 18 years to be 14% [10]. Furthermore, one-half of first episodes of depression occur during adolescence [10]. Suicide is the third leading cause of death among teenagers, with about half of these associated with depression [11].

The high prevalence and costs of childhood and adolescent depression, the associated negative long-term psychiatric and functional outcomes and the association between depression and attempted or completed suicide, demonstrate that efforts to prevent and intervene early in depression is warranted. Evidence-based prevention programs targeting depression in at-risk youth have yielded promising results [10, 12]. A systematic review conducted to identify and describe school-based prevention and early intervention programs for depression and to evaluate their effectiveness in reducing depressive symptoms demonstrated that indicated programs which targeted students exhibiting elevated levels of depression were found to be the most effective [12] although there are methodological problems including the lack of attention to control conditions [13]. To date there is little evidence of long-term effect with many of the studies [13, 14] but the Coping with Stress course [15] showed a reduction in depressive episodes at follow-up. This study has recently been replicated [16] and this is the most promising intervention to date although research in a less highly targeted group is warranted.

There are a number of targeted and universal prevention programs that show evidence of short-term reduction in symptoms of depression including The Coping with Stress Course, the Penn Resiliency Program, and FRIENDS.

There has been a great deal of interest in the use of internet programs to increase availability of interventions. Whilst there is some evidence showing that these programs may be helpful, this evidence is not robust and completion of the programs remains problematic. However this is an approach for which further research and development is worth pursuing. As well as prevention and early intervention, appropriate and effective treatment for depression is also important for improving the treatment and outcomes of young persons, and to reduce the risk of suicide.

Recommendation:

2 Improved detection and management of depression; ongoing education regarding identification and appropriate treatment of the different types of depressive disorder should be provided to General Practitioners in particular

3.1.3 Indigenous and rural communities

Evidence shows Indigenous Australians aged 12-24 have suicide rates four times greater than non-Indigenous Australians; [18] this disparity is even greater for men in rural and remote communities. Suicide is more concentrated in the earlier adult years for Aboriginal and Torres Strait Islander people than for other Australians. In recent years, the rate of suicide for Aboriginal and Torres Strait Islander males was highest in the 15 to 34 year age group [1]. Furthermore, non-reliable data may be under-identifying Indigenous status meaning that the figures could be even higher. While overall suicide rates have remained relatively stable over the last century, Indigenous suicide rates are generally increasing [2, 29]. The past 10 years has also seen a higher rate of suicide amongst people, particularly males, in rural and remote areas, with the most significant increases in communities with populations of less than 4,000. This points to the need for a focus on youth suicide particularly in these areas.

Aboriginal suicide has unique social and political contexts, thus interventions or prevention campaigns should target this high risk group in a culturally appropriate manner. More information about the cultural problems experienced by Indigenous youths in their teenage years is needed to determine appropriate targeted programs and services. Young people in the justice system may need personal support; 6% of young Aboriginal men (aged 25-30 years) in Australia are in prison at any one time, while up to a quarter of all young Aboriginal men will have direct involvement with correctional services each year [30]. These figures are especially worrying given that the first 6-12 months following release from prison is a high risk time for suicide. In order to bridge the gap in health inequalities that Aboriginal and Torres Strait Islander people face, it is vital that any suicide policy developed gives this area priority.

An important source of information about the social and emotional well-being of Aboriginal and Torres Strait Islander children and youth is the Western Australian Aboriginal Child Health Survey, a large-scale, scientifically rigorous survey that included attention to the developmental and environmental factors that enable competency and resiliency in Indigenous children and young people aged 4-17 years [31]. The survey found that 24% of Indigenous children were rated by their parents as being at high risk of clinically significant emotional or behavioural difficulties, compared with 15% in the general Australian population [32]. For Aboriginal and Torres Strait Islander people, the development of resilience is particularly important given the ongoing impact of serious disadvantage and poorer health outcomes [33].

All mental health professionals should undertake regular cultural awareness training in order to develop a better understanding of the social and emotional requirements of Aboriginal and Torres Strait Islander people. Further, increasing the availability of tailored services to Indigenous Australians and other groups whose needs are not well met by mainstream services is also warranted if services are to be more effective in future.

There is a pressing need to determine if young people, especially in rural areas, have adequate access to the professional expertise needed to diagnose and treat mental disorders [34]. Social disadvantage influences suicide rates as people with lower levels of education are grossly over represented in suicide rates.

***Recommendation**:*

3 An increase in the number of community services that can provide holistic longer term care for Aboriginal and Torres Strait Islanders that are proficient in recognising mental health issues. The

Commonwealth government should invest in mental health generally and suicide identification and prevention specifically for Indigenous populations

3.2 Improved reporting

Development of a cross sector suicide reporting system that is easy to use and allows accurate data reporting is essential. Accurate statistics provide the foundation for appropriately targeted prevention strategies and research and understanding the full costs of suicide. Without reliable data, the effectiveness of suicide prevention strategies is not detectable. It is therefore vitally important to ensure that there is accuracy in suicide reporting. Additionally, there is also a need for improved data on self-harm, and how this interacts with suicide data.

There is a general acceptance that deaths from suicide are under-reported. In Australia, current research has determined that national suicide under-reporting probably grew from 2002 to 2006 [17]. There are a number of systemic reasons for difficulty in reporting accurate national suicide figures, including:

- the absence of a central authority for recording and reporting mortality data;
- data is collected for different purposes by multiple parties with different standards of proof and reporting timelines;
- there are inconsistent coronial processes for determining intent due to inadequate information inputs, suicide stigma, and high standards of proof;
- there are problematic collection and coding methods for data stakeholders; and
- there is lack of systemic resourcing, training and shared expertise.

The lack of information in death records on some characteristics of people dying by suicide further contributes to the ignorance of suicide risk factors and distribution. Evidence shows for example that Indigenous Australians aged 12-24 have suicide rates four times greater than non-Indigenous [18], but where non-reliable data under-identifies Indigenous status, this can hamper measurement and analysis. Further gay, lesbian, bisexual and transgender status is seldom recorded despite these groups' over representation in suicide and self-harm [19], and this may be particularly relevant in youth suicide. Stigma associated with suicide may have an effect on coronial reporting. From a public health perspective, social stigma about suicide and self-harm must be tackled if widespread under-reporting is to stop. As part of the process to improve reporting, families bereaved by suicide must be involved in helping to reduce the stigma associated with it.

A number of Australian and international studies have considered the social impact of media reports on suicide and mental health or illness, particularly in regard to youth suicide. Research suggests that in certain circumstances reports about suicide can lead to imitation or 'copycat' suicide attempts by vulnerable people in the community. Therefore care should be taken to report the issues in a sensitive way and to ensure that accurate information is given [22]. There is also evidence that suicide being reported in a sensitive manner may reduce suicide rates, particularly when the emphasis is on suicide as a tragic and avoidable loss, avoiding sensationalising or glorifying coverage with excessive details, and includes discussion of sources for help.

Media reporting is of particular concern for school-age children who are especially vulnerable to media influences. Australian reporting has demonstrably improved in response to media reporting guidelines [23, 24]. However, increases in awareness have not necessarily translated into increased willingness to seek help [25]. Concerns about inappropriate media reporting and public discussion about suicide, must be balanced against the costs of silence about a major social problem. Comprehensive media guidelines that the media are aware of and use are essential.

The RANZCP strongly supports improved consistency and reliability of serious event reporting, and the rigorous review of serious events. With better systems of reporting, the full extent of the potentially serious consequences of mental illness can be analysed and preventable deaths avoided through improved strategies.

***Recommendations**:*

4 Improvements to the system of national suicide reporting and the recording of presentations to hospitals of people who present with self harm are required to ensure consistent, accurate, reliable, and timely reporting. This will require:

(iii) Increased resources and funding to achieve agreed criteria for suicide reporting across the sector.

(iv) Improved breakdown of suicide rates for high risk groups and by ethnicity.

5 Coroners, clinicians and those bereaved by suicide should collaborate to reduce stigma associated with suicide

6 The media should be aware of and use guidelines for the reporting of suicide

3.3 Improved education and training

Improved community and practitioner mental health literacy through the use of education programs aimed at identification of, and support for, those at suicide risk is essential.

Suicide prevention is not limited to health services. Suicide prevention includes a range of interventions focused on community or organisational gatekeepers whose contact with potentially vulnerable populations provides an opportunity to identify at-risk individuals and direct them to appropriate assessment and treatment. Gatekeepers include those employed in institutional settings, such as schools or after school activity coordinators [21] , GPs and other health professionals, as well as parents and peers. There is a need for much improvement in the role of these gatekeepers in the prevention of suicide. Improving people's knowledge of mental illness can lead to a greater recognition and understanding of mental health, increased help-seeking and support [20], and educating those who are most likely to come into contact with people with mental illness can increase community support and lead to early intervention and prevention.

Relevant interventions include awareness of risk factors, policy changes to encourage help-seeking, availability of resources, and efforts to reduce stigma associated with help-seeking. In addition to gatekeeper training, programs are required to promote organisation-wide awareness of mental health and suicide, and facilitate access to mental health services. There is generally evidence that gatekeeper training is effective, important and relevant. However, to date, systematic evaluation of gatekeeper training on suicidal behaviour has largely been limited to multilevel programs conducted in institutional settings, such as the military where programs in the Norwegian Army and the US Air Force have reported success in lowering suicide rates [21]. Additionally, at present, much of the focus of evaluation is on the

training process rather than the clinical outcomes. Whilst it is useful to demonstrate information can be learnt, further research into the translation of training to the actual outcome of preventing suicide is necessary.

***Recommendation**:*

7 Training, education and support should be provided for gatekeeper staff to recognise and assist people who are experiencing a suicidal crisis, and the effectiveness of this training evaluated

3.4 Improved research and evaluation

Suicide prevention research programs must be coordinated at the highest level with strategic leadership to ensure effective outcomes.

There is much room for improvement of research into suicide and suicide prevention. Government support and collaboration is essential for developing and improving the research program; currently there is a lack of transparency and coordination. Recent studies have sought to inform priority setting in Australian suicide prevention research by seeking stakeholders' views on where future priorities might lie, and undertaking reviews of current literature [35, 36]. These studies highlight that priority should be given to evaluating the efficacy of specific interventions and examining the response of the health and community service systems; this assertion is strongly supported by RANZCP.

Emphasis should be on intervention studies and evaluative activities that focus on groups identified as having particularly high levels of risk of suicide. Identifying effectiveness of suicide prevention programs is essential to inform both policy makers prior to developing strategy, and practitioners and community organisations in how to minimise risk. There is also a need for further research into self-harm and suicide attempt survivors.

There is currently no evidence to demonstrate that the current National Suicide Prevention Strategy is the best way to reduce suicide rates. There is a critical need for systematic reflection of the strategy and a commitment to reviewing strategies and publishing their effectiveness. Suicide attempt survivors can uniquely contribute to this process by identifying their individual needs and guiding the development of effective prevention and aftercare strategies in a de-stigmatising manner [37]. There should be systems developed to review and monitor the National Suicide Prevention Strategy with a commitment to evaluation and publication of data reflecting the effectiveness of programs.

Currently the literature in equivocal on the value of public awareness campaigns: there is limited evidence that the campaigns work although there is also limited evidence that the campaigns are counterproductive. This issue is further confused by a low base rate of suicide figures which makes the effectiveness of suicide prevention strategies difficult to analyse [21]. Until there is sufficient evidence and analysis of these programs, it is not possible to make a determination on effectiveness. The RANZCP supports further research in this area. Awareness campaigns should not only focus on prevention, but also increase community awareness regarding treatment and support options, including the role of different health practitioners, youth mental health services, and other relevant community supports in order to be beneficial for consumers, carers and their families.

Of particularly relevance is the current National Health and Medical Research Council rule on active parental consent versus passive parental consent. Previously, researchers were able to ethically obtain a vast majority of school-age children to answer questionnaires. This allowed conclusions to be drawn about the population which led to informed strategies for early intervention of suicide. With the demand for active parental consent from all ethics committees, in several studies over the last few years

responses to such surveys have only managed to be obtained from a small majority of the target populations. This invalidates the research, and any possible conclusions drawn. Without this research base, planning early intervention strategies for youth suicide is virtually impossible.

***Recommendation**:*

8 All suicide prevention strategies should be evaluated with at least 15 per cent of all funding allocated to suicide prevention strategies being spent on evaluation

9 Collaboration is required between Federal and State governments in regard to funding research in suicide prevention, including the appointment of an expert body to oversee all research into suicide prevention that is linked formally with academic institutions

10 Further research, evaluation and analysis into the effectiveness of suicide prevention public awareness campaigns is necessary

3.5 Reducing access to means of suicide

Availability of the means of suicide is also of high significance to suicide rates. Public health approaches (planned or unplanned) aimed at decreasing the availability of lethal, culturally accepted methods of suicide have resulted in an overall decline in suicide rates. The RANZCP supports continued reduction to access to suicide means

Recommendation:

11 Access to means of suicide needs to be reduced through specific legislation to reduce access to paracetamol

3.6 Increased resources for prevention and early intervention of mental illness

Prevention and early intervention of mental illness in infants, children and adolescents is an essential part of youth suicide prevention.

Suicide risk factors and processes often extend back to early childhood. Psychological, biological, and illness-related factors interact with family, school and wider socio-cultural environments. Crucial to suicide prevention in youth is the prevention and early intervention of mental illness in childhood and adolescence. Strategies for the prevention and early intervention of mental illness should cover all age-groups from 0 – 18 years although specific suicide prevention strategies are required for adolescents, including for suicide attempters. Further information on specifically suggested programs can be found in section 3.1.

Critical to the success of the prevention and early intervention of mental illness in childhood, is broadening the roles and priorities of child and adolescent psychiatrists and general psychiatrists to include the provision of leadership to multidisciplinary teams, training of other professionals, and advocating for improvements in service delivery and for enhanced focus on such programs.

Recommendation:

12 Introduction and maintenance of rigorously evaluated prevention and early intervention programs for the prevention of mental illness across all age groups, with a particularly focus on depression, suicide and self-harm in adolescence

4. Conclusion

Mental illness and youth suicide are closely intertwined and must be addressed concurrently to ensure a holistic approach to improving outcomes. Suicide prevention should address factors that cause people to become suicidal, including enhancing social inclusion and improving services for both general and high-risk groups. Increased support should be provided for those in the role of gatekeeper, including those who deliver crisis response, in identifying and responding to suicide risk. Accurate reporting of suicide and self-harm figures and comprehension evaluation of the effectiveness of current programs is imperative to the success of future suicide prevention strategies.

There is a need for a coordinated and national approach, across all age groups, to achieve development and implementation of robust suicide prevention strategies. It is strongly recommended that consideration is given to how this Inquiry into Youth Suicide Prevention can be integrated with the ongoing work of the Australian Suicide Prevention Advisory Council and the outcomes from the current Senate Inquiry into Suicide in Australia.

The Royal Australian and New Zealand College of Psychiatrists thank the House of Representatives Standing Committee on Health and Ageing for the opportunity to make a submission to this matter.

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