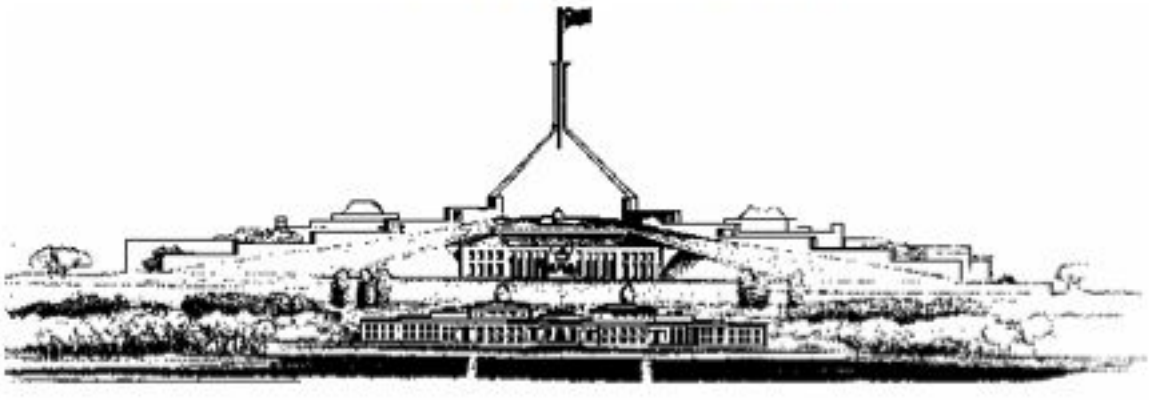
COMMONWEALTH OF AUSTRALIA

PARLIAMENTARY DEBATES



HOUSE OF REPRESENTATIVES

Main Committee

COMMITTEES

Health and Ageing Committee

Report

SPEECH

Wednesday, 6 July 2011

BY AUTHORITY OF THE HOUSE OF REPRESENTATIVES

SPEECH

Date	Wednesday, 6 July 2011	**Source**	House
Page	7907	**Proof**	No
Questioner		**Responder**	
Speaker	Irons, Steve, MP	**Question No.**	

Mr IRONS (Swan) (12:44): I rise to speak on the Standing Committee on Health and Ageing report tabled on Monday, titled *Before it's too late*, about youth suicide in Australia. The report focused on early intervention programs aimed at preventing youth suicide and covered two parliaments, those being the 42nd Parliament and the 43rd Parliament. I notice the member for Kingston is here in the chamber, who was on the committee during the 42ndParliament. It is regretful that she has left the committee and was not able to continue with her support on this particular inquiry. But I was very pleased when, in the 42nd Parliament, we decided to do this report, even though the Senate was also running a committee inquiry into suicide. As it states in the report:

Although the … Committee was aware that the Senate Community Affairs Reference Committee had already initiated a comprehensive inquiry into suicide in Australia, it felt that a House of Representatives inquiry, if appropriately focussed, could complement that work.

Initially, when I requested that the committee look at the possibility of doing an inquiry into youth suicide, it was because of my personal involvement with groups such as Youth Focus and the Esther Foundation and as the patron of SIDS and Kids in Western Australia. It was also because I had met with parents who had experienced the loss of their children through suicide. As human beings we know that we are all going to have to deal with the loss of loved ones at some stage, whether it be through natural causes, accidents or suicide. Our communities have to deal with the effects of suicide, and that does provide many challenges for families, friends and schools, and those effects can be very damaging in more ways than the experience of grief. We could see that in the evidence we took, with cluster suicides now, unfortunately, becoming more common.

On Monday, when the report was tabled, I spoke about some personal experiences to bring a human touch to the launch of this report on suicide, which sees the loss of far too many of our most precious resource: the children and youth of our communities. I also spoke about the fact that as a nation we provide many millions of dollars to prevent road accidents and deaths in the workplace; I hope that this report will encourage our nation to provide and support early intervention programs that will reduce the number of suicides, whether they be youth or older people who take this step for many different reasons. Figures show that, in 2004, 500 more Australians committed suicide than died in road accidents in Australia.

On Monday I also detailed some of the important parts of this report and I would like to continue with that. I restate that the level of concern about the statistics on youth suicide is due to the fact that the statistics are not nationalised, with many states keep differing records, and this needs to be addressed. Statistics on suicide in Australia are available from a number of sources. National data on suicide is published in some years by the Australian Bureau of Statistics, the ABS. The most recent data, published in 2007, contains summary statistics on deaths registered in 2005 where the cause of death was determined to be suicide. Even more recent, though less comprehensive, statistics on suicide in Australia are published annually in the ABS Causes of Death reports. The most recent report, released in 2011, provides information on suicides based on mortality data from 2009.

Coroners, through the National Coroners Information System, NCIS, are another significant source of suicide data. In addition, the Australian Institute of Health and Welfare has produced a number of publications based on information extracted from the AIHW mortality database. These data are supplemented by data collection and research conducted by academic institutions and community based organisations.

It is clear that there is a range of information on suicide being collected by different organisations with different collection and reporting standards. The committee understands that the lack of a nationwide, systematic approach limits the usefulness of suicide information. However, it is also evident that the problems associated with data collection on and the reporting of suicide, including youth suicide, are well recognised. In relation to this, the committee acknowledges that the ABS has already made significant efforts to implement reforms to improve the accuracy and quality of data on suicide and these processes are ongoing.

The first two recommendations of the committee's report are in regard to statistics. Recommendation 1 reads:

The Committee recommends that the National Committee for the Standardised Reporting of Suicide consider options for, and the feasibility of, extending the scope of social and demographic suicide data routinely collected and reported on, to include information on:

ethnicity;

culture;

geography;

educational attainment;

employment status; and

socio-economic status.

Recommendation 2 reads:

The Committee recommends that the National Committee for the Standardised Reporting of Suicide consider options for providing increased access to disaggregated suicide data.

The report goes on to say:

Of particular relevance to the issue of youth suicide, the Committee notes Recommendation 28 of the Senate report which calls for the ABS (and other relevant public agencies) to record and track suicides and attempted suicides in children aged under 15 years. As noted earlier in this Chapter, registered suicides in this group are relatively uncommon, though for a range of reasons it is likely that the reported figures are an underestimate. While acutely aware of the difficulties of establishing suicidal intent in this age group, and the extreme sensitivity for the families concerned, the Committee is keen to support initiatives which ensure that suicide in this demographic is not 'hidden'. The Committee believes that appropriate recognition of suicide in the under 15 year age group is needed to ensure that prevention initiatives do not neglect these children. The Committee notes that the Senate recommendation has been referred to the ABS.

I know in my role as the patron of SIDS and Kids in Western Australia that the issue of suicide up to the age of 14 is handled by organisations such as SIDS and Kids, and they should be able to provide their statistics to a national body as well.

The report then moves into the area of understanding the factors that influence the likelihood of suicide. That will assist in developing strategies to reduce suicide rates. A significant body of research already exists which indicates that many factors contribute to the likelihood that someone will consider or attempt suicide or not. These factors generally act to either increase the likelihood of suicide—risk factors—or decrease this likelihood —protective factors.

Risk and protective factors are also categorised according to the level at which they are present—that is, individual, social and broad contextual. The report lists commonly cited risk and protective factors within each of the three categories. The risk factors for individual are listed in the report as:

gender (male)

mental illness or disorder

chronic pain or illness

immobility

alcohol and other drug problems

low self-esteem

little sense of control over the circumstances

lack of meaning and purpose in life

poor coping skills

hopelessness

guilt and shame

The risk factors for social are:

abuse and violence

family dispute, conflict and dysfunction

separation and loss

peer rejection

social isolation

imprisonment

poor communication skills

family history of suicide or mental

illness

The risk factors for contextual are:

neighbourhood violence and crime

poverty

unemployment, economic insecurity

homelessness

school failure

social or cultural discrimination

exposure to environmental stressors

lack of support services

The committee understands that there is a complex array of factors associated with suicide and cautions against an overly simplistic view of youth suicide and its causes. Access to accurate and comprehensive data and an improved understanding of the influence of risk and protective factors on young people are needed to support an improved understanding.

The committee recognises, however, that, while this will assist the identification of populations or groups at increased risk of suicide, it will still not be possible to precisely identify individuals at risk—hence the need for early intervention strategies. The committee understands that the main value of this information is to provide a good evidence base to inform the development and appropriate implementation of strategies for reducing rates of youth suicide and to enable effective evaluation of the impact of interventions.

Current approaches to suicide prevention in Australia are considered in chapter 3 of the report, including recently announced additional funding targeting suicide prevention by the government. I would like to mention that we in the coalition took a policy of early intervention to the last election. We committed to provide $440 million

in funding towards 20 early psychosis intervention centres in major metropolitan and regional areas. These centres were to be based on the existing EPPIC model and were to provide comprehensive and targeted care for young Australians aged 15 to 24 years at clinical high risk and with first episode psychosis. The centres would have provided intensive interventions aimed at recovery and prevention of relapse. Four hundred million dollars was committed towards system design, service evaluation, workforce development, medical and allied health costs, case management, home and mobile care, and vocational recovery assistance provided by early psychosis intervention centres. Forty million dollars was to be provided towards additional capital costs of the centres.

There are many parts to this report, but one part that I took particular interest in was the gatekeeper training. One of the difficulties with early intervention is identifying individuals who need support and ensuring they get it. While noting that some have expressed reservations with the use of the term 'gatekeeper', in this context it is simply used to describe a diverse range of individuals who have regular contact with young people. These people include family, friends, teachers, youth workers, sports coaches, health professionals, law enforcement personnel and emergency services personnel. As noted in the submission from the Australian Psychological Society:

Each of these groups of people play two critical roles: to act as ‘detectors’ and monitor for early warning signs of young people at risk; and to act as ‘facilitators’—alerting and making appropriate referrals to specialist service providers as required.

Evidence suggests that building mental health literacy and providing ongoing training for people who have regular contact with young people so that they are better equipped to recognise early warning signs and make appropriate referral is likely to have benefits. Representing Lifeline Australia, Mr Alan Woodward reported:

We have found through our training of community personnel and what are known as ‘gatekeepers’—our health workers, youth workers and social workers and the like; people who are likely to come into contact with a suicidal person—that being able to explore that issue and provide an immediate and appropriate response is a very important step. We believe that that is also an area of suicide prevention which is known to be effective internationally and could be invested in further in Australia

Considering youth suicide prevention specifically, it is clear that family, friends and teachers have a significant role when it comes to managing the wellbeing of young people. Importantly, the committee does not expect these groups to assume the role of counsellor. Rather, the committee considers that it would be useful for parents, peers and teachers to be trained to recognise the signs of mental distress and be equipped to start a conversation providing 'at risk' young people with advice on the resources that are available or putting them in contact with a specialist service.

While acknowledging that teachers are already carrying significant responsibility when it comes to the health and wellbeing of young people, the committee believes that they are ideally placed as professionals, who have regular contact with young people, to play a significant role in the early identification of young people who may be experiencing difficulties and needing assistance. I am sure that any teacher would be willing to have the gatekeeper training, even if it meant saving only one life during their career.

Recommendation 10 of the report states:

The Committee recommends that teachers receive mandatory training on mental health awareness, including specific training to develop their capacity to recognise and assess suicidal risk.

The time to tackle mental illness is when it first occurs. Early intervention is important and the real focus of this report is on early intervention. As Patrick McGorry has said:

Evidence shows that with early and targeted treatment many young people are able to overcome their problems and return to health and lead socially and economically productive lives with lower incidence of progression or relapse.

Conversely, delay can be damaging, particularly for adolescents.

It is with this in mind that I conclude by thanking all the young people who made submissions to our inquiry. I thank them for their courage, as it made the committee's job easier. I see that the member for Robertson, who was on the committee, is in the chamber. I know that the evidence we took during that time was disturbing, but it was

great to hear that the evidence that the young people gave was able to assist us in making the recommendations in this report. I thank everyone who was involved, particularly the secretariat and the chairman, the member for Hindmarsh. I commend the report to the House.