The Royal Australian & New Zealand College of Psychiatrists

Commonwealth Treasury

2019–20 Pre-Budget submission

advocating for mental health resources commensurate with the burden of disease

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Royal Australian and New Zealand College of Psychiatrists

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About the Royal Australian and New Zealand College of Psychiatrists

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) is a membership organisation that prepares doctors to be medical specialists in the field of psychiatry, supports and enhances clinical practice, advocates for people affected by mental illness and advises governments on mental health care. The RANZCP is the peak body representing psychiatrists in Australia and New Zealand and as a bi-national college has strong ties with associations in the Asia-Pacific region.

The RANZCP has over 6000 members including more than 4000 fully qualified psychiatrists and around 1500 members who are training to qualify as psychiatrists. Psychiatrists are clinical leaders in the provision of mental health care in the community and use a range of evidence-based treatments to support a person in their journey of recovery.

Introduction

The RANZCP is pleased to provide this submission for the 2019-2020 Australian Commonwealth Budget. Mental illness accounts for 12.1% of Australia's total burden of disease, third highest behind cancer (19%) and cardiovascular diseases (15%).[1] Despite this, only 7.7% of government health expenditure is dedicated to mental health-related services.[2] This leaves significant unmet need within the Australian community.

The RANZCP advocates that a proportional increase in mental health spending, including targeted investment in several key areas, is required. We believe that directing funds towards mental health care should be understood as an investment with the potential to generate high returns and that improving the mental health of the community is likely to have flow-on effects for the broader economy including increasing workforce participation and decreasing pressure in the health, social services and justice systems.

Acknowledging that the chronic underfunding of the mental health sector cannot be undone in a single budgetary cycle, the RANZCP recommends prioritisation of funding initiatives in 2019-20 under the following seven key topics:

- rural access and the psychiatric workforce
- substance use and addiction
- Aboriginal and Torres Strait Islander mental health
- mental health needs of older people
- disability support and the NDIS
- mother and baby mental health
- suicide prevention.

[1] AIHW (2011) Australian Burden of Disease Study. Impact and causes of illness and death in Australia. Canberra, Australia: Commonwealth of Australia.

[2] AIHW (2018) Mental health services in Australia. Available at: https://www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia/report-contents/expenditure-on-mental-health-related-services (accessed 29 November 2018).

Summary of recommendations

Rural access and the psychiatric workforce

1.1 Increase the funding for project support for the Specialist Training Program and the Rural Training Pipeline for Medicine initiative by $500,000 over three years.

Alcohol and other drug services

2.1 Introduce a minimum floor price for alcohol that includes volumetric taxation with direct revenue from alcohol taxation towards preventative health activities (including a focus on alcohol-related harm) and alcohol and other drug treatment services.

2.2 Develop a national quality framework for AOD services that determines accreditation and funding of public and private services.

Aboriginal and Torres Strait Islander mental health

3.1 Increase funding for Aboriginal and Torres Strait Islander mental health and wellbeing services based on needs-based expenditure targets of at least 2.4 times greater than for the general population.

3.2 Increase recruitment of Aboriginal and Torres Strait Islander mental health workers in public health services in targeted locations, with appropriate supports provided including mentoring, debriefing and supervision.

Mental health needs of older people

4.1 Establish an Aged Care Information Strategy Standing Committee and implement a trial for the collection of operationalised indicators of compliance with best practice at a cost of $1 million over three years.

4.2 Expand the number of Specialist Dementia Care Unit beds from 371 beds to 500 beds at a cost of $25 million annually.

Disability support and the NDIS

5.1 Ensure evaluation is conducted by PHN at local levels to investigate service gaps so funding is appropriately provided to minimise people being without suitable services for their mental health care.

5.2 Clarify referral pathways and services throughout relevant health networks to ensure continuous service provision is achieved as much as is possible for those not in the NDIS and affected by the change in services. This should include communications through primary, secondary and tertiary health points to minimise patients being without appropriate services.

Mother and baby mental health

6.1 Introduce models of care for the antenatal management of severe mental illness as part of the maternity health services accessed by pregnant women and after birth.

6.2 Introduce public mental health mother and baby units in all Australian states and territories, equating to one eight-bedded unit for every 15,000 deliveries at a cost of $90 million over three years.

6.3 Improve data collection for perinatal mental health assessments by implementing a pilot trial of data collection around Australia a cost of $360,000 over three years.

Suicide prevention

7.1 Allocate funding for national suicide prevention initiatives to specifically address the needs of key population groups including males aged between 15 and 34, Aboriginal and Torres Strait Islander peoples and people in rural and remote locations.

Rural access and the psychiatric workforce

The RANZCP is committed to ensuring those living in rural and remote Australia have equitable access to healthcare and is guided in this work by the RANZCP Section of Rural Psychiatry. Health Workforce Australia's *Health Workforce 2025* report identified that psychiatry is facing significant shortages both now and into the future. The report found that the more remote the location, the worse the access to psychiatric services[3]. In addition, a RANZCP survey of psychiatry trainees found that only 65% of trainees would consider working in a regional centre and only 37% in a rural or remote area[4]. Unfortunately, these figures indicate that the trend of workforce maldistribution is likely to continue into the future without significant intervention to incentivise and support rural practice.

Specialist Training

The Specialist Training Program (STP) and the Integrated Rural Training Pipeline for Medicine (IRTP) support a more equitable distribution of workforce in Australia. Incentivising and supporting trainees to train in rural and remote areas is critical to ensuring the workforce is more evenly distributed and not concentrated in metropolitan areas. It is pleasing to see the recent change from an annual to a three agreement for the delivery of STP training. Renewal of the contract at least 12 months prior to the end date is important to ensure continuity of the program as services and providers require this length of time for forward planning and recruitment.

The recent prioritisation of places in the rural setting is supported. However, the increased emphasis on rural placements has come at the cost of the funding for support that is provided to trainees in the form of Rural Educational Grants, Educational Webinars for Rural Trainees and Mentoring Program for rural trainees and Aboriginal and Torres Strait Islander trainees. Rural trainees reported that the educational grants made a real difference to access educational learning activities and networking opportunities to support the completion of training assessment requirements. Some trainees also reported that these grants were one of the most significant initiatives provided to trainees located in a rural location and strongly supported that they continue to be available in the future. The Educational Webinars for Rural Trainees, which were also well received by trainees, delivered a series of educational and interactive webinars for rurally-based trainees covering topics such as 'eating disorders', 'addiction', among others. Due to funding constraints, the Mentoring Program for rural trainees and Aboriginal and Torres Strait Islander trainees which can fund a limited number of partnerships to attend the introductory event, no longer allows for the provision of a small grant for the partnerships to meet face to face at another event (e.g., Congress).

This is a loss of $500,000 over three years.

Recommendation 1.1 Increase the funding for project support for the Specialist Training Program and the Rural Training Pipeline for Medicine initiative by $500,000 over three years.

[3] Health Workforce Australia (2012) Health Workforce 2025 – Volume 3 – Medical Specialities. Adelaide: HWA.
[4] Royal Australian and New Zealand College of Psychiatrists (2014) Report on the Trends in Admission to Fellowship Survey 2011–2013, 31 July.

Alcohol and other drug services

Substance misuse is a significant concern to psychiatrists and the public, as well as being a cause of significant morbidity and mortality, with associated impairment and other psychosocial consequences for individuals as well as their families and communities. Excessive alcohol consumption has a detrimental effect on mental health with a well-documented relationship between alcohol abuse and mental health issues. The combination of alcohol misuse and depression presents a tragically high-risk profile for suicidal behaviour and suicide[5]. At the same time, drugs such as crystal methamphetamine are quickly becoming one of the most serious issues confronting frontline mental health services and emergency departments.

Developing a holistic, nationally coordinated and evidence-based response to substance needs to be understood as an important investment, with significant potential for return on investment across the health and justice systems, as well as the broader economy.

There is a significant gap between demand and the provision of services with a severe undersupply of addiction treatment services in Australia. There is an urgent need for expansion of alcohol and other drug services including withdrawal management services.

Alcohol reform

As outlined in the RANZCP Recognising and reducing alcohol-related harm[6], the RANZCP supports evidence-based approaches to reducing the availability and accessibility of alcohol. These include: independent regulation of the marketing and advertising of alcohol; limiting the alcohol accessibility through the numbers of outlets that sell alcohol as well as their hours of service; and raising of alcohol prices through excise taxes and the introduction of a minimum price per standard unit of alcohol[7].

The RANZCP is concerned that there has been no progress on pricing and taxation reform since the launch of the National Alcohol Strategy 2018–2026 earlier in 2018. Previous experience with smoking has demonstrated the importance of pricing reform as part of a coordinated approach to supporting behaviour change.

Recommendation 2.1 Introduce a minimum floor price for alcohol that includes volumetric taxation with direct revenue from alcohol taxation towards preventative health activities (including a focus on alcohol-related harm) and alcohol and other drug treatment services.

High quality services

The RANZCP supports evidence-based approaches to alcohol and other drugs (AOD) services. Developing a holistic, nationally coordinated and evidence-based response to AOD misuse should therefore be understood as an important investment, with significant potential for return on investment. To ensure that Australians have access to high-quality, evidence-based programs, the RANZCP

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[5] Sher L (2006) Alcoholism and suicidal behaviour: a clinical overview. *Acta Psychiatrica Scandanavica*, 113: 13–22; Hufford M (2001) Alcohol and suicidal behavior. *Clinical Psychology Review* 21: 797–811.

[6] Royal Australian and New Zealand College of Psychiatrists (2016) Position Statement 87: Recognising and reducing alcohol-related harm. Available at: https://www.ranzcp.org/News-policy/Policy-submissions-reports/Document-library/Recognising-and-reducing-alcohol-related-harm (accessed 14 December 2018).

[7] Grossman M, Chaloupka F, Saffer H, Laixuthai A (1994) Effects of alcohol price policy on youth: A summary of economic research. *Journal of Research on Adolescence*, 4: 347–64; New Zealand Law Commission (2009) *Alcohol in our lives: an issues paper on the reform of New Zealand's liquor laws* (Issues Paper 15). Wellington, New Zealand: NZLC.

believes there is an urgent need to develop a national quality framework that sets standards for AOD services including the development of formal accreditation standards for rehabilitation facilities.

Recommendation 2.2 Develop a national quality framework for AOD services that determines accreditation and funding of public and private services.

Aboriginal and Torres Strait Islander mental health and wellbeing

There is a significant portion of the Aboriginal and Torres Strait Islander population who continue to experience very high levels of psychological distress, hospitalisation for mental health disorders, self-harm and suicide. When it comes to mental health, the Aboriginal and Torres Strait Islander burden of disease is estimated to be 2.4 times greater than the non-Indigenous burden. This includes Aboriginal and Torres Strait Islander adults experiencing high or very high psychological distress at almost three times the level of non-Indigenous adults, and being hospitalised for mental and behavioural disorders at twice the rate of non-Indigenous Australians. Moreover, hospitalisation rates for self-harm increased by 50% between 2005 and 2013 while the rates for non-Indigenous Australians are stable.[8]

The importance of improving outcomes for the Aboriginal and Torres Strait Islander population is highlighted in the Senate Inquiry report into Accessibility and Quality of Mental Health Services in rural and remote Australia. The committee recommended that the Commonwealth Government prioritise the development of implementation and evaluation plans for the National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2017–2023 (2018).

Investment to reduce the gap

The RANZCP is committed to contributing to the reduction of inequality in mental health outcomes between Aboriginal and Torres Strait Islander peoples and other Australians and is guided in this work by the RANZCP's Aboriginal and Torres Strait Islander Peoples Mental Health Committee. In recognition of the importance of collaborating to improve outcomes, a partnership agreement was signed in May 2017 between the Council of Presidents of Medical Colleges (CPMC), the Australian Indigenous Doctor's Association (AIDA), the National Aboriginal Community Controlled Health Organisation (NACCHO) and members of the Australian Government. Known as 'Partnering for good health and wellbeing for Aboriginal and Torres Strait Islander Australians', this partnership has already resulted in a strategic framework to improve the mental health and wellbeing of Aboriginal and Torres Strait Islander peoples. To progress work on these shared priorities, the RANZCP advocates for the provision of funding to support action under the partnership's strategic framework.

Furthermore, plans to place a cap on program funding for Aboriginal Controlled Community Health Organisations are concerning, particularly considering the fact that per capita spending on Aboriginal and Torres Strait Islander health remains less than needs-based funding estimates.[9] The RANZCP urges the government to increase funding for culturally appropriate services to ensure that health inequities for this group do not widen further.

Recommendation 3.1 Increased funding for Aboriginal and Torres Strait Islander mental health and wellbeing services, including via the expansion of ACCHOs, based on needs-based expenditure targets of at least 2.4 times greater than for the general population.

Aboriginal and Torres Strait Islander mental health workers

The complexity of mental illness issues for Aboriginal and Torres Strait Islander peoples necessitates an understanding of a range of cultural, historical, familial and societal issues. Language, stereotyping,

[8] Productivity Commission for the Steering Committee for the Review of Government Service Provision (2016) Overcoming Indigenous Disadvantage: Key Indicators 2016. Productivity Commission, Canberra.
[9] Australian Medical Association (2018) AMA Report Card on Indigenous health. Available at: https://ama.com.au/system/tdf/documents/2018%20AMA%20Report%20Card%20on%20Indigenous%20Health_1.pdf?file=1&type=node&id=49617 (accessed 22 November 2018).

stigma and mental health literacy may also pose barriers to Aboriginal and Torres Strait Islander consumers accessing appropriate and effective care. Aboriginal and Torres Strait Islander mental health workers have an important role to play in the negotiation of these barriers.

Aboriginal and Torres Strait Islander mental health workers include people working in a wide range of roles in both governmental and community-controlled organisations with varied qualifications, skill sets and criteria. These practitioners may be working in the area of mental health or emotional, social and spiritual wellbeing, cultural liaison and community engagement, or a combination. More information on the benefits of Aboriginal and Torres Strait Islander mental health workers can found in our Position Statement 50: Aboriginal and Torres Strait Islander mental health workers.

Recommendation 3.2 Increased recruitment of Aboriginal and Torres Strait Islander mental health workers in public health services in targeted locations, with appropriate supports provided including mentoring, debriefing and supervision.

Mental health needs of older Australians

Older people represent a rapidly growing proportion of the Australian population, with the 65 and over age group expected to more than double by the 2050s.[10] The ageing population in Australia will result in increased demand for mental health services for older people, as those with long standing mental illness are joined by others with mental illness that develops for the first time in later life.

Older Australians, particularly vulnerable populations such as those in residential aged care, face a number of unique barriers, issues and complications when accessing care for mental illness. Concerning data from the AIHW shows 85% of people in permanent residential aged care have at least one diagnosed mental health or behavioural condition, and 47% had a diagnosis of depression.[11] Older people with mental illness are also more likely to face over-prescribing within the health system, and have prescription rates at 500% of that of the general population for anxiolytic, hypnotic, and sedative drugs.[12]

While the Royal Commission into Aged Care Quality and Safety (2018) will provide the research, analysis and evidence to design a safe and high quality aged care system for the future, there is an urgent need to instigate measures of safety and quality.

Safety and quality

On this basis, the RANCZP, on the advice of the RANZCP Faculty of Old Age Psychiatry, is advocating for greater monitoring and transparency in the aged care system, in addition to top up resources for mental health services for older Australians. Funding should be directed towards establishing an Aged Care Information Strategy Standing Committee, which can guide the collection and evaluation of operationalised indicators of compliance with best practice in 15 aged care trial sites around Australia. Indicators of compliance could include rates of psychotropic use, rate and reasons for hospital admissions, advance care planning undertaken by general practitioners and compliance with obtaining consent. The total cost of this measure would be $1 million over three years.

Along with these national benchmarked indicators, there needs to be specification in the newly introduced Aged Care Quality Standards of evidence that the aged care providers have the systems and workforce in place to provide access to quality mental health care. This evidence could include the number of referrals to mental health services, the waiting time for residents for access to mental health services, the training levels and accreditation of care staff in the facility and the type of mental health services received by residents. This measure is particularly targeted at ensuring that staff in aged care providers have the appropriate training in mental health care, particularly dementia care, to ensure the needs of older Australians are met.

Recommendation 4.1 Establish an Aged Care Information Strategy Standing Committee and implement atrial for the collection of operationalised indicators of compliance with best practice at a cost of $1 million over three years.

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[10] Australian Bureau of Statistics (ABS) (2013). Population projections, Australia, 2012 (base) to 2101. ABS cat. no. 3222.0. Canberra, Australia: ABS.
[11] Australian Institute of Health and Welfare (AIHW) (2017) People's care needs in aged care. Canberra, Australia: AIHW. Available at: https://gen-agedcaredata.gov.au/Topics/Care-needs-in-aged-care (accessed 11 September 2018).
[12] Hollingworth S, Lie D, Siskind D, Byrne G, Hall W, Whiteford H (2011) Psychiatric drug prescribing in elderly Australians: time for action. *Australian & New Zealand Journal of Psychiatry* 45: 705-708

Specialist dementia care units

The RANZCP welcomes the introduction of Specialist Dementia Care Units (SDCU) to provide services for those with very severe behavioural and psychological symptoms of dementia (BPSD). While this is a step in the right direction, the RANZCP has concerns that the resourcing for the implementation of SDCUs falls short and will fail to address current gaps in care for consumers with very severe BPSD.

The Brodaty et al. model indicates that very severe BPSD is present in up to 1% of all people with dementia, which denotes 3,540 of the estimated 354,000 living in Australia with dementia in 2016. While it is feasible that some of these individuals will be managed in other care settings, the contribution of only 372 beds across Australia is demonstrably inadequate. We are advocating to address this gap in care in coordination with state and territory governments, at an additional cost of $25 million per year.

Recommendation 4.2 Expand the number of Specialist Dementia Care Unit beds from 371 beds to 500 beds at a cost of $25 million annually.

Disability support and the NDIS

The National Disability Insurance Scheme (NDIS), while providing for some, has left a significant gap in service provision for many. With the absorption of many community mental health services and funding being linked to the NDIS, many services are no longer available to individuals who are not eligible for the NDIS. This has left a significant gap for many Australians who previously had access to mental health services. A report conducted by a think tank of 58 stakeholders at the University of Sydney estimates that up to 166,000 – 626,000 people or 91% (depending on the figures used) of people with a severe mental illness will need to rely on non-NDIS services[13]. Many of this majority currently rely on community mental health care. The NDIS has changed the landscape of community mental health services and, with transition to NDIS service provision, has left some individuals now ineligible for these services.

The RANZCP is committed to ensuring those who are not participating in the NDIS, for whatever reason, have equitable access to mental health services. While the RANZCP welcomes the commitment of the federal government to providing funding to Primary Health Networks (PHNs) it is imperative that these organisations adequately resolve the service provision gaps found in many areas across Australia effectively. Current investigations in to gaps in mental health services provision, like the Primary Health Network Mental Health Lead Site, do not define whether the areas which have been directly affected by the implementation of the NDIS will be part of the analysis. Robust data into the degree and scope of gaps in service provision due to the advent of the NDIS is important in ensuring effective measurements can be taken to address these gaps in a timely manner.

Recommendation 5.1 Ensure evaluation is conducted by PHN at local levels to investigate service gaps so funding is appropriately provided to minimise people being without suitable services for their mental health care.

Recommendation 5.2 Clarification of referral pathways and services throughout relevant health networks to ensure continuous service provision is achieved as much as is possible for those not in the NDIS and effected by the change in services. This should include communications through primary, secondary and tertiary health points to minimise patients being without appropriate services.

[13] University of Sydney & Community Mental Health Australian (CMHA) (2018) Mind the Gap: The National Disability Insurance Scheme and psychosocial disability, Final Report: Stakeholder identified gaps and solutions. The University of Sydney Policy Lab. Available at: http://sydney.edu.au/health-sciences/documents/mind-the-gap.pdf (accessed 28 November 2018).

Mother and baby mental health

Women are at greater risk of developing a mental illness following childbirth than at any other time, and the effects of post-natal mental illness can be devastating on mother, baby and the surrounding community. Without adequate management, symptoms and associated impairment of functioning can sometimes persist for years, and there is clear research linking schizophrenia and psychotic disorders, bipolar disorder and eating disorders with increased risks and complications for pregnancy.[14]

Currently women with severe mental illness in Australia currently have limited access to specialist perinatal mental health care within maternity care. On this basis, specialist mental health management and support for women with mental illness prior to, during pregnancy and in the postnatal period should be a priority area for the Federal government. Significant government investment is required to establish a model of care which integrates antenatal management of severe mental illness into maternity health services.

Recommendation 6.1 Introduce models of care for the antenatal management of severe mental illness as part of the maternity health services accessed by pregnant women and after birth.

It is now widely accepted that women requiring inpatient treatment have improved outcomes if accompanied by their babies. Admitting both mother and baby to hospital circumvents the possibility of women refusing inpatient treatment in order to avoid being separated from their children[15] and is well demonstrated to be effective in treating perinatal illness.[16] In order to provide the best possible care, mothers in Australia should have access to dedicated 24 hour Mother Baby Units (MBUs), to provide inpatient treatment of mental illness for antenatal and postnatal women as well as supervision and support of the care of the baby as clinically indicated.

However, currently there are limited publically funded MBUs in Australia for inpatient mental health treatment that offer a full inpatient service (24/7). These are located in Victoria, Western Australia, South Australia and Queensland. This leaves women in New South Wales, Northern Territory, Australian Capital Territory and Tasmania without access to Mother Baby Inpatient Mental Health Services. While the RANZCP acknowledges the New South Wales State government has committed to introduce MBUs, it is crucial that this commitment be followed through in 2019 after the New South Wales election.

The RANZCP urges the Federal government to work collaboratively with State and Territory governments to allocate funding of $5 million for each unit per year for at least 3 units in New South Wales, 1 unit in the Northern Territory, Australian Capital Territory and Tasmania. This would require an investment of $30 million per year.

Recommendation 6.2 Introduce public mental health mother and baby units in all Australian states and territories, equating to one eight-bedded unit for every 15,000 deliveries [17] at a cost of $90 million over three years.

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[14] Judd F, Komiti A, Sheehan P, Newman L, Castle D, Everall I (2014) Adverse obstetric and neonatal outcomes in women with severe mental illness: To what extent can they be prevented? *Schizophrenia Research* 157(1):305-9.
[15] Salmon M, Abel K, Cordingley L, Friedman T, Appleby L (2003) Clinical and parenting skills outcomes following joint mother-baby psychiatric admission. Australian and New Zealand Journal of Psychiatry 37(5): 556–562.
[16] Wilson D A, Bobier C, Macdonald E M (2004) A perinatal psychiatric service audit in New Zealand: patient characteristics and outcomes. Archives of Women's Mental Health 7(1): 71–79.
[17] Royal College of Psychiatrists (2015) Perinatal mental health services. London, UK: RC Psych. Available at: https://www.maternalmentalhealth.org.uk/wp-content/uploads/2015/09/RCPsych-Perinatal-mental-health-services-recommendations.pdf (accessed 30 November 2018)

Data collection

The allocation of resources towards mother and baby health needs to be guided by robust and ongoing data collection. The RANZCP acknowledges that work is continuing by the AIHW and other groups to enhance maternity data collection and reporting in Australia, however we would encourage the government to prioritise the development and addition of several specific mental health data items to the National Perinatal Data Collection.

These three data items are 'antenatal depression/anxiety screening conducted', 'additional follow-up indicated due to the identification of perinatal mental health risk factors' and the 'presence or history of mental health condition'. The Federal government should invest in the collection and evaluation of these data items, beginning with a pilot trial in six sites around Australia, including 3 metropolitan and 3 rural and remote at a cost of $360,000 over three years.

Recommendation 6.3 Improve data collection for perinatal mental health assessments by implementing a pilot trial of data collection around Australia a cost of $360,000 over three years.

Suicide prevention

In 2017, 3,128 people died from intentional self-harm in Australia. This was an increase of 9.1% (from 2,866) in 2016.[18] This reflects the growing crisis of suicide in Australia, as well as the inadequacy of repeated mental health plans and strategies to curb the unacceptable increase in suicide deaths.

While the RANZCP welcomed the Fifth National Mental Health and Suicide Prevention Plan (the Fifth Plan), and relevant funding towards suicide prevention from the Federal government, more is needed to prevent the suicide rate from continuing to increase. It is concerning to the RANZCP that the 2018 Progress Report on the Fifth Plan found that there were no significant achievements identified in the area of suicide prevention, reflecting the need for this policy area since the plan was implemented.

It is clear that the complexities associated with suicide mean that no one single intervention can be expected to prevent suicide and, as such, suicide prevention strategies must be comprehensive not only in longevity but also in their breadth. An important aspect of comprehensive services is ensuring that they meet the needs of specific population groups that may be at higher risk of suicidal behaviours.

Statistics show that suicide deaths occur disproportionately in certain communities, cultures and demographics. Deaths from intentional self-harm occur among males at a rate more than three times greater than that for females. When age-specific rates are considered, suicide accounted for over one-third of deaths among people aged 15 to 24 years, and over a quarter of deaths among those aged 25 to 34 years.[19] The rate of suicide deaths per 100,000 increases consistently with greater remoteness. The rate of suicide deaths in very remote areas, 23 deaths per 100,000 people, was more than double the rate in major cities, 10.1 deaths per 100,000 people.[20]

For Aboriginal and Torres Strait Islander peoples rates of suicide are particularly concerning. In 2017, suicide ranked as the second leading cause of death for Indigenous males, with 39.6 deaths per 100,000 persons and 7th for Indigenous females, at 11.9 deaths per 100,000 persons.[21] For comparison, in the non-Indigenous population, suicide ranked as the 10th and 21st leading cause for males and females, respectively. Targeted services are needed, as part of overarching programs and services, to ensure that at-risk groups are supported and engaged by a range of mental health and social supports.

Recommendation 7.1 Allocate funding for national suicide prevention initiatives to specifically address the needs of key population groups including males aged between 15 and 34, Aboriginal and Torres Strait Islander peoples and people in rural and remote locations.

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[18] ABS (2018) 3303.0 Causes of Death, Australia, 2017. Available at: http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/3303.0~2017~Main%20Features~Intentional%20self-harm,%20key%20characteristics~3 (accessed 27 November 2018)
[19] Ibid.
[20] Torrens University (2018) Remoteness – Australia. Available at: http://www.phidu.torrens.edu.au/current/graphs/sha-aust/remoteness/aust/premature-mortality-cause.html (accessed 30 November 2018).
[21] ABS (2018) 3303.0 Causes of Death, Australia, 2017. Available at: http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/3303.0~2017~Main%20Features~Intentional%20self-harm,%20key%20characteristics~3 (accessed 27 November 2018).