Royal Commission into
Victoria's Mental Health System

WITNESS STATEMENT OF ALAN WOODWARD

I, Alan Woodward, say as follows:

1 I make this statement on the basis of my own knowledge, save where otherwise stated. Where I make statements based on information provided by others, I believe that information to be true.

2 My evidence to the Royal Commission is provided in my personal capacity, and not as a representative for any of the entities I have worked with.

Background and qualifications

3 I have worked in the field of suicide prevention for the past twenty years. Throughout, I have approached suicide prevention from a policy and program perspective, rather than a clinical approach, and focused on service delivery and community action.

4 I currently work as an independent consultant specialising in suicide prevention and mental health. I offer strategic advice, specialist assistance with program design and development, and evaluations, data and research translation. I provide advice to Mental Health Victoria and several other clients in Victoria.

5 I am currently a Strategic Advisor to Suicide Prevention Australia, and provide advice on quality and innovation for the Australian suicide prevention services sector; many services are delivered through Members of Suicide Prevention Australia. I was previously a director of Suicide Prevention Australia for nine years.

6 In August this year, I take up a part-time appointment as a Commissioner with the National Mental Health Commission.

7 Previously, I worked at Lifeline Australia from 2004 to 2018 in senior executive roles. I was appointed Executive Director Research and Strategy from June 2017 and was the Executive Director of the Lifeline Research Foundation from 2011 – 2017. Prior to that I held the roles of General Manager National Services, General Manager Social Policy Innovation Research and Evaluation.

8 My academic background is in social policy, research and public administration. I hold a Masters of Social Science and Policy Studies from the University of New South Wales, a Bachelor of Business (Public Administration) from Charles Sturt University.

9 I am currently a PhD candidate with the University of Melbourne, Centre for Mental Health, School of Population and Global Health, on the research topic of Caller Experiences and Impact of Telephone Helplines.

10 Attached to this statement and marked "**AW-1**" is a copy of my Curriculum Vitae, which sets out further details of my qualifications and career to date.

Suicide prevention

11 It should be noted from the outside that suicide is a complicated behaviour:

- It is difficult to detect because people may not disclose their suicidality;
- It may fluctuate in intensity rapidly and unpredictably;
- It cannot be reliably predicted beyond a point in time;
- It is dangerous and potentially lethal – to the individual and those around them;
- It is influenced in part by social factors and the attitudes and actions of others.

12 So, suicide is one of those 'sticky problems' in our society – it requires a broad multi-factorial strategic approach across the spectrum of awareness raising, detection, early prevention, crisis intervention and recovery. This is now referred to as a systematic approach to suicide prevention. Programs and services need to be configured around this strategic framework.

13 There is no single action, service or treatment that will work in isolation. Suicide prevention therefore is an area of policy, strategy, service and community action that will require concerted, continuous and coordinated effort to be effective.

What do you mean by "suicide prevention"?

14 The phrase "suicide prevention" has a few layers, which are important to explore.

15 One level is the **prevention of deaths**, which is clearly very important. Safety and the prevention of death is a high priority for suicide prevention. Like many, I work in this field because I believe that these deaths are preventable.

16 But it is important to note that suicide prevention also has other layers and levels, which reflect the complex nature of suicide.

17 We seek to prevent **suicidal behaviour** such as attempts to end a life which can lead to significant disabilities and injury. We want to prevent those disabilities and injuries. It is estimated from ABS National Mental Health and Wellbeing Survey that 30 times as

many people attempt to end their life each year as die by suicide.[1] Even greater numbers experience suicidal crisis without attempting to die.[2] This amounts to many people's suicidality experienced as periods of significant distress and difficulty – this should not be forgotten in the societal response to suicide.

18 Another aspect is understanding that suicidal behaviour has a destructive **impact on people outside the individual**. This is perhaps the most noteworthy where the behaviour results in death, where other people suffer bereavement and loss. Suicide attempts can also have major impacts on other people.

19 Research has shown that the impact of suicide deaths and behaviour on others is so profound that it is a public health concern;[3] suicide has a broad reach into our society and literally thousands of people are affected by it. The impact of suicide is not restricted only to those who die or attempt to end their lives.

20 Prevalence of exposures studies, for example, show that 4.3% of the population having exposure to suicide in the past 12 months, and 21.8% exposure in their lifetime.[4] Additionally, Australian research led by Professor Myfanwy Maple and US researcher Julie Cerel has found that up to 125 people may be impacted by one suicide death – around half of whom may be family with others including work colleagues, social contacts and business associates.[5] Earlier research examined by Frank Campbell (Past President of the American Association of Suicidology in USA) when formulating the argument for a broader approach to post-suicide supports, mapped 28 different relationships that are impacted by one person's suicidality – immediate and extended family, social, workplace, professional and community relationships.[6] This perspective is represented in the voices of those with lived experience of suicide who often refer to the profound impact of another's death by suicide on their own wellbeing, and the struggles of those who care for suicidal persons through periods of crisis and recovery.

21 Overall, to best understand suicide and the behaviours that flow from it, we should view a person's desire not to live as an expression of profound **human suffering**. In the 1950s and 1960s, leaders in the field such as Ed Shniedman called this deep pain

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1 Australian Bureau of Statistics 2007 National Mental Health and Wellbeing Survey

2 *Ibid*

3 Maple, M., Cerel, J., Sanford, R., Pearce, T. & Jordan, J. (in press), 'Is exposure to suicide beyond kin associated with risk for suicidal behavior? A systematic review of the evidence', Suicide and Life Threatening Behavior, Accepted 10 June 2016.
Pitman, A., Osborn, D., King, M., Erlangsen, A 2014, 'Effects of suicide bereavement on mental health and suicide risk', The Lancet, Suicide 3 Series, DOI: dx.doi.org/10.1016/S2215-0366(14)70224-X.

4 Andriessen, K; Rahman, B; Draper, B; Dudley, M; Mitchell, P. 2017. Prevalence of Exposure to Suicide: A Meta Analysis of Population Based Studies. Journal of Psychiatric Research.

5 Maple, M., Kwan, M., Borrowdale, K., Riley, J., Murray, S. & Sanford, R. (2016) 'The Ripple Effect: Understanding the Exposure and Impact of Suicide in Australia'. Sydney: Suicide Prevention Australia

6 Campbell, F. R. 1997. Changing the Legacy of Suicide. Suicide and Life Threatening Behavior. Vol 27(4).

"psych-ache" and observed that the suicidal person is mostly driven by ending this pain and not seeing a way to achieve this without ending their life.[7]

22 Therefore, suicide prevention needs to be understood as an endeavour in preventing human suffering first and foremost – with the policy, program and service responses contributing to this fundamental feature of human suicidality and its experience.

What is the overlap between suicide and mental illness?

23 This has been the subject of extensive discourse.

24 Over the last five to ten years, we have seen changes in this discourse across both the research community and the suicide prevention field. There is now broad recognition that while mental health may be a factor in suicidal behaviour, it is not the only factor and it may not even be the primary factor. Suicidal behaviour is formed from multiple factors, rarely one single factor.

25 Conversely, people who experience mental health issues are overrepresented amongst people who die by suicide at a rate of seven times – or more for some mental health conditions, according to reports from SANE Australia. So, for some people, mental health illness is a significant factor in suicidal behaviour.

26 The salient point is: some but not all or even many people with mental health issues die from suicide. We need to be careful not to apply a causal relationship between the two.

27 Furthermore, from a public heath perspective efforts to improve the overall mental health and wellbeing of the population will generate a commensurate reduction in suicidal behaviour. This has been demonstrated in studies such as those involving the European Alliance Against Depression.[8]

28 At the individual level, the provision of mental health services and treatments in accessible and timely ways will also serve to reduce that individual's vulnerability to suicide, simply by ensuring that their mental ill health is addressed in effective ways so that they can live healthy and participating lives. A mental health system should see this as the outcome it seeks at all times. In doing so, the profound pain associated with

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7 Shneidman, E. 1993. Suicide as Psychache: A Clinical Approach to Self-Destructive Behavior. London. Jason Aronson Inc.

8 Hegerl U, Althaus D, Schmidtke A, Niklewski G. The alliance against depression: 2-year evaluation of a community-based intervention to reduce suicidality. Psychol Med 2006; 36: 1225–33.

Hegerl U, Mergl R, Havers I, et al. Sustainable eff ects on suicidality were found for the Nuremberg alliance against depression. Eur Arch Psychiatry Clin Neurosci 2010; 260: 401–06.

Hubner-Liebermann B, Neuner T, Hegerl U, Hajak G, Spiessl H. Reducing suicides through an alliance against depression? Gen Hosp Psychiatry 2010; 32: 514–18.

mental ill health will be addressed and alleviated. This can be especially important for people experiencing mental health crisis periods.

29 We also need to give attention to co-morbidity situations where mental health is experienced alongside substance/alcohol abuse, chronic physical ill health and pain and various social determinants of wellbeing, as part of our approach to suicide prevention. The performance of the mental health system must include its capabilities to create linkages to a range of services and supports on a holistic basis.

30 Critically, the mental health system must be prepared and competent to address suicide on the basis that its consumers are vulnerable and may become suicidal while under care. We need to ensure that providers and professionals in the mental health system are skilled to deal with suicidal behaviour and to contribute to more integrated approaches to suicide prevention.

Global best practice

31 There is one key dossier on global best practice of the evidence and effective suicide prevention: namely, the WHO 2014 report *Preventing Suicide: a global imperative*[9] (**WHO Report**), which was based on years of research and expert advice. The report is relevant to Australia, including because we are a Member State of the World Health Organisation and have committed to implementing the recommendations.

32 The WHO Report recommends, for example, a holistic approach to suicide prevention. On page 11 of this Report, under the heading that Suicide is Preventable, the authors clearly make this point:

"These efforts must be comprehensive, integrated and synergistic, as no single approach can impact alone on an issue as complex as suicide."

33 This means national strategies need to cover health, mental health, substance abuse, addictions, economic and social factors, employment and education, individual, family and community situations. The WHO Report provides a clear mandate for a 'whole of Government' multi-portfolio approach to suicide prevention, with the involvement of public, private, community and civil society sectors.

34 The WHO Report outlines 11 components for an integrated suicide prevention strategy on page 57, covering the range of approaches across the full public health spectrum of care: promotion and prevention, early intervention and crisis intervention, aftercare and recovery supports.

[9] https://www.who.int/mental_health/suicide-prevention/world_report_2014/en/

35 The Fifth National Mental Health and Suicide Prevention Plan incorporates these 11 components in setting the strategic approach to suicide prevention in Australia. Reform in suicide prevention needs to focus on a coordinated effort in implementing this strategic approach, across all tiers of Governments and with the engagement of all sectors in the wider community.

Are there any elements of the WHO Report which warrant more attention in Victoria?

36 All components of the WHO Report are being implemented to some extent in Victoria. The Victorian Suicide Prevention Framework gives attention to a range of strategic responses that align broadly to the WHO recommendations on strategy. But certain areas do warrant more attention.

37 For example, in Victoria, good progress has been made by conducting a series of trials: aftercare and place-based trials. The HOPE Trials – which are exploring alternative crisis response facilities to conventional Accident and Emergency Departments for people experiencing a mental health or suicidal crisis – can be strongly supported in the evidence on what works in suicide prevention and the insights from people with lived experience of using the hospital system in times of crisis. Similarly, the Place Based Trials are seeking to coordinate approaches at a community level to various factors for suicide prevention. Both these initiatives reflect the reform directions presented at a national and international level.

38 The question is – "what should happen following the trial periods?" While trials are useful for prompting new ways of providing services and supports, and for galvanising attention to suicide prevention across multiple stakeholders, the question is how to apply the knowledge that is obtained. Knowledge gained from excellence in research and rigorous evaluation is vitally important, but that knowledge must be translated into service improvements, practices and continual development of approaches to prevent suicide.

39 My concern is that while some regions in Victoria have benefited from trials, there needs to be more consistency across the State. As the trials move into the delivery of services phase, there needs to be an application of what is being learnt from them and translation into more consistently improved services for all Victorians, regardless of where they live.

40 A key development that needs to occur in Victoria is the establishment of a consistent service model for crisis response and aftercare – for the hospital, community mental health services and the community support services to operate in ways that facilitate better experiences for people who have suicidal crisis and their carers. The results of the HOPE Trials should inform this, but a comprehensive model of service that includes

appropriate crisis responses and aftercare for suicidal persons and their carers should be regarded as a necessary part of the State's suicide prevention strategy. Budgets and workforce investments to realise this model on a continuing basis need to be set.

41 Another area for improvement is a properly structured, resourced and planned regional approach to suicide prevention. Nationally there is a commitment to regional approaches to suicidal behaviour. This recognises that suicide prevention needs to be place-based and responsive to the variations in vulnerability and protective factors for suicide prevention from region to region.

42 Regional factors such as socio-economic conditions can have significant impacts on suicide prevention; State-wide views of these factors do not necessarily translate into lower or higher risk levels in regions. Factors at play in different regions will warrant different priorities. Factors can include demographic aspects such as high migration rates, ages across population, education levels and occupational elements (for example, some regions have concentrations of certain occupations which are at higher risk of suicide, such as farming and agriculture). Social capital levels and community capacity surrounding social supports and wellbeing may vary across regions.

43 The notion of a regional approach to suicide prevention is very sound in light of the regional differences. This approach will require investments in the structures, the personnel, the allocation of resources, the programs and services and the community networks that allows for better coordination and collaboration across service mixes, and allows for community engagement.

44 Victoria needs a more targeted and committed regional approach to suicide prevention. This approach needs to be formalised and confirmed beyond the Place Based Trials initiatives.

45 In my view, Victoria is lagging behind other states in this regard. For example, in South Australia there has been a recent commitment to create and resource regional suicide prevention networks linked to regional health networks. This has been mandated to include local governments, and community connection is encouraged through the composition of the networks and the selection of services and programs that includes community education and outreach. An Office of Suicide Prevention within the Premier's portfolio responsibilities has been established to provide high-level leadership and ensure that a whole of government approach is adopted. In my view, this will work well in driving a more cohesive and coordinated set of actions for suicide prevention. It is an approach that is also building capacity for suicide prevention close to the local factors that need to be addressed, across government, private and community sectors and with a coordination function set at the highest level. Similar commitments have been made in Queensland and New South Wales and will be proceeding.

Are there any cohorts who are particularly at risk?

46 There are commonalities in cohorts of people who are sometimes termed priority populations for attention to risk of suicide across the nation. The ABS Causes of Death reports and epidemiological research has given us insights into priority populations.[10] For instance:

(a) men account for three out of every four deaths by suicide in Australia;

(b) Aboriginal and Torres Strait Islanders experience double the national suicide rate, noting that some communities have suicide rates that are equal to the highest in the world;

(c) people from LBGTI backgrounds have much higher suicide rates, possibly more than seven times the national rate;

(d) farmers and residents in rural areas experience double the national suicide rate. Veterans suicide rates are higher than the broader community rate; and

(e) people working in particular occupations have higher suicide rates:

(1) emergency services workers;

(2) health professionals;

(3) police; and

(4) construction workers.

47 We therefore have visibility through the data on suicide deaths on those populations that we need to give particular attention to in our outreach, our service configurations and provision.

48 In Victoria there is the benefit of having the remarkable data depth that is available through the Victorian Suicide Register – a national lead in data compilation and reporting capability that can be used to better understand the priority populations in Victoria and adjust our suicide prevention action accordingly.

49 We also need to consider the data on suicidal behaviour – to monitor the numbers and the trends across populations and circumstance that signal increased (or decreased) suicidal behaviour. This means monitoring data from hospitals and health services, police and emergency services, where suicidal behaviour may be responded to and therefore visible in operational data and reports.

[10] Australian Bureau of Statistics 3303.0 Causes of Death Report.

50 For instance: there has been an increase in suicidal behaviour in young women across the nation, and this is also the case in Victoria, as reported in the Orygen report on youth suicide.[11]

51 Suicidal behaviour can also be seen to relate to trigger and transition issues. For instance, an Australian Institute for Suicide Research and Prevention has found males who transition through relationship breakdown were more likely to die by suicide than the broader male population.[12] Similarly research summarised by the WHO Report, and by Australian researchers such as Allison Milner on the social determinants of suicide has identified that suicidal behaviours may be associated with experiences of negative life events including domestic violence and substances abuse, as well as the onset of mental ill health such as depression. This knowledge suggests that attention is warranted in relation to how services are offered and how life event issues affecting people are addressed at particular transition points or times of vulnerability and struggle – for suicide prevention.

Why hasn't Victoria been able to reduce the suicide rate?

52 It is hard to have a simple answer to this question. There is no single answer; the question continues to perplex those of us who work in the sector. However, there are a number of different ways of looking at the issue.

The number of deaths is only one way to assess effectiveness

53 First, it is important to note that the number of deaths recorded in a given year is only one way to access the effectiveness of suicide prevention methods, given the broader concept of suicidal behaviour as outlined above. In a given year, various factors may combine to affect the number of suicide deaths.

54 Rather, it is more useful to examine suicide rates over a longer period of time – say five or ten years. In doing so, we find that for Australia these rates have been fairly stable at around 11, 12 or 13 per 100,000 people. However, in recent years there has been a slight increase. This is concerning and requires greater examination.

We cannot say "everything is not working"

55 Second, the point should be made in relation to the counter-factual; that is, to consider what may have been the case had strategies, programs and services not been in place. While we are disappointed that the suicide rate in Australia is stable and now slightly higher, we need also to be careful to avoid quick judgements that our programs or

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11 Orygen National Centre of Excellence in Youth Mental Health 2016 Raising the Bar For Youth Suicide Prevention.

12 Kolves, K; Ide, N; De Leo, D. 2009. Suicidal Ideation and Behaviour in the Aftermath of Marital Separation: Gender Differences. Journal of Affective Disorders.

services are failing. In considering the counterfactual, if there had not been the work undertaken in suicide prevention, the suicide rate could have been higher. Media commentary can be focused on the message that it is a "terrible situation" and it is – we are talking about people dying and loss and suffering. But we cannot say "everything is not working".

56 Some things are working well. We know this by making comparisons to other countries and noting that Australia is not having the highest suicide rate, or even the highest amongst western developed nations – especially the USA.[13]

57 We also have research and evaluation evidence that shows some of our programs and services are making a measurable difference.[14] For example, research published on the Mates In Construction program has quantified the lower suicide deaths in construction industry populations associated with the program's impact in those states where that program is active (not Victoria, unfortunately).

58 Another example is crisis helplines – in Australia we have very good tele-web crisis support services. Suicidal persons contact these services – the Australian and international research studies suggest that around one third of callers to crisis helplines will be 'actively suicidal'.[15] People who are suicidal use these services because they are available when no others are open and because they are confidential and accessible ways to seek immediate help. This is why the WHO has recently released a guideline on the use of crisis helplines for suicide prevention.[16] On a daily basis, people who are on the brink of suicide are calling these helplines. Crisis interventions to ensure safety are preventing loss of life. The Lifeline service alone, taking more than 2,500 calls a day, is undertaking suicide safety planning with more than 125 people each day.[17] We should recognise that this happening and that these services contribute to moderating the suicide rate.

Deficiencies in the management of strategies

59 A third consideration is that the suicide rate has not significantly reduced because of deficiencies in the management of our strategies. There can be inadequate coordination of effort and there are insufficient resources. I am acutely aware of how thin the resources can be on the ground for services related to suicide prevention. We do not

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13 USA – 13.4 and Australia 12.6 in 2016; WHO Report in 2014 shows USA at 12.1 and Australia at 10.6 in 2012.

14 Doran, C.M; Ling, R; Gullestrup, J; Swannell, S; Milner, A. 2015. The Impact of a Suicide Prevention Strategy on Reducing the Economic Cost in the New South Wales Construction Industry. Crisis. Vol 37(2).

15 Alan Woodward and Clare Wyllie. Helplines, Tele-Web Support Services and Suicide Prevention. In: The International Handbook of Suicide Prevention, Second Edition, Edited by: Rory C O'Connor and Jane Pirkis. 2016.

16 Preventing Suicide: A Resource for Establishing a Crisis Line. World Health Organisation 2018.

17 Lifeline Australia, Annual Report 2017-2018.

have universal coverage in Australia or Victoria on a range of important services, such as:

(a) aftercare;

(b) workforce training;

(c) immediate supports for people in suicide crisis;

(d) schools based prevention programs; and

(e) bereavement supports for those impacted by suicide.

60 Too often what is available depends on where the person lives and what services or facilities are within their reach. It is to be acknowledged that government, community and private funding has more than doubled in past decade. However, the investment in suicide prevention has not been a commensurate to that made, for example, in respect of road deaths. There has a significant investment in road safety and a significant reduction in road deaths. There continues to be a need for more in suicide prevention.

61 A further question arises here: in relation to the funding that does exist - has it been deployed in the most efficient and effective way?

62 For suicide prevention programs and services, funding needs to be allocated against service plans that are based on population needs and a balanced assessment of the mix of nature of services to align with the components of a suicide prevention strategy. Too often, we do not have a clear picture of the funding allocations to services against a calculated level of investment to ensure the suicide prevention strategy is fully operable.

63 There is also a need to develop measures of program and service effectiveness in achieving those components of the suicide prevention strategy that they are able to. Too often the reporting, monitoring and evaluation is on the basis of activity, such as numbers of people through a program, episodes of service, or website downloads, rather than reach and outcomes related to that program activity.

64 At a government level, suicide prevention funding should not be confined to the mental health budget. Suicide prevention should be conceived more broadly than mental health, and there are other areas of government areas that need to be resourced for suicide prevention, including:

(a) family support;

(b) housing; and

(c) juvenile justice.

65 These are important areas for suicide prevention because the issues and life circumstances that they are addressing may be factors in a person's suicidality, and because they provide points of contact with persons who may be suicidal and could be approaches with the offer of help – earlier and more effectively than waiting for a suicide attempt to occur.

66 For example, there are too many young people who die by suicide that are known by child protection agencies to be vulnerable. The Queensland Commissioner for Children and Young people estimated in 2014 that about one third of children who died by suicide were known to child protection authorities.

67 When we talk about funds for suicide prevention – we really should be talking about the whole services sector – health, education, employment, community and social services. We should support community services that drive community strength, connectivity and wellbeing. State governments do all of these things, but do not have line items for suicide prevention. A whole of government view of the budgets, programs and results for suicide prevention is required.

Insufficient coordination between programs and services

68 A fourth answer is that there is not great coordination between the various programs and services that are operating for suicide prevention. This is exacerbated by the tiers of government in Australia – we can have situations where both Federal and State Governments are funding services or programs (aftercare is an example) or neither are investing in growing services (bereavement support). Role and responsibility clarity and accountability across tiers of government is needed for improved overall 'system' performance.

Population-level changes can influence suicidal behaviour

69 Finally, it is also important to take into account the factors that surround suicidal behaviour – either those factors that may prompt or perform a protective role with regard to suicidal behaviour. Suicide may be understood as a human behaviour that is influenced by personal, situational and social factors. Recent theory on suicide prevention such as the Integrated Motivational Volitional Model by Professor Rory O'Connor and others has adopted this approach with growing research evidence to demonstrate the operation of key factors, for instance: the experience of entrapment.

70 The social behavioural perspective points to the need to have wide-scale responses for suicide prevention when major change affects large pockets of the population. Change that impacts the population, or a large part of the population, can drive suicidal behaviour. Economic change as it affects some people is an example. Major research studies by Shu-Sen Chang and Professor David Gunnell have considered the impact of

the global financial crisis on suicide rates, finding that those countries that withdrew service supports from people affected by the economic crisis often saw increases in suicide rates.[18]

71 Similarly, social change can leave some pockets of the population perceiving that they are left out – that the previous networks and connections that they had with people were disappearing. An example of a vulnerable population in Australia presently is older people – notably older males who have now the highest suicide rate of any age cohort.

How should suicide prevention be measured?

72 The question of how to measure the effectiveness of suicide prevention measures is hard to answer. There is not a lot of data to say what works well within the context of a defined program or service – we are too reliant on high level data.

73 There are some programs we can currently examine for effectiveness. For example, the WHO Report makes a recommendation regarding the management of media and public commentary on suicide, as this is a key factor in suicide prevention. Australia does well in this regard, for example through Mindframe – the national program that delivers training for journalists and the related Mindframe Guidelines – we can measure and monitor our media comment on suicide and see that preventative action is occurring.

74 However, there is currently inadequate agreement and detail on how to measure suicide prevention strategies in a comprehensive and consistent way across States and Commonwealth – or at a regional level.

75 Moreover, we do not have the data sets we need. For example, there is no definition of "suicidal behaviour" for hospitals to use and track presentations. There is only a definition for "intentional self-harm"

76 We do not have data to review what happens to people who present to our hospital and health systems for suicidal intent or behaviour. We cannot, at this stage, report on re-attempts of suicide in a reliable and consistent manner in Victoria, or nationally. Yet, this is a key performance measure of the service system for suicide prevention, as we have well established research evidence to suggest that 40% of suicide deaths are by people who have previously attempted suicide.

77 We also need to collect and monitor data on underlying population levels of suicidality. That is, the proportion of the Australian – or state – populations that self-report a level of suicidal ideation and/or behaviour in a given period. This is data that will tell us if the upstream efforts to reduce whole of population vulnerability to suicide are being

[18] Chang, Shu-Sen and Gunnell, David, et. al 2009. Was The Economic Crisis 1997-1998 Responsible for Rising Suicide Rates in East-Southeast Asia? Social Science and Medicine. Vol 68.

effective because it provides a measure of the population wide shifts, positively or negatively, towards underlying suicidality. The effectiveness of broad strategies to prevent suicide can be tested against this measure. This data can be collected across the national population through population surveys. This dataset was last measured federally in 2007 through the ABS National Mental Health and Wellbeing Survey, but ideally should be measured every five years so that changes and trends can be monitored with the results feeding into strategic priorities and adjustments to our suicide prevention efforts.

Recommended initiatives and ideas – especially in relation to the concept of distress and human suffering.

78 The humanitarian dimension of suicide warrants a lot more attention because ultimately suicide is about a state of human suffering which, unchecked, can lead to tragic consequences.

79 State governments are well placed to address the humanitarian dimension because they are often providing services through their health, family and community and education portfolios that directly address experiences of individual and social disadvantage. State Governments are also well placed to deliver programs that connect to communities and foster community strengths. They also are able to utilise Local Government with regard to community building and social inclusion activities.

80 In extending the humanitarian dimension of suicide, there should be more post-suicide support services so that those who are impacted by the profound loss and grief of another's suicide are properly supported in a timely way. For example the Standby Response services that provide immediate support post a suicide death to families, carers, workplaces and others could be made generally available to Victorians.

81 There needs to be more consistent and accessible bereavement support services to engage with people who have experienced the loss of someone to suicide - this is sometimes called postvention. One thing we know is that people and sub-communities can become vulnerable to suicide themselves when a member has died by suicide.[19] [i]We can see this in particular with young people, for example, where "clusters" of suicidal behaviour can develop.

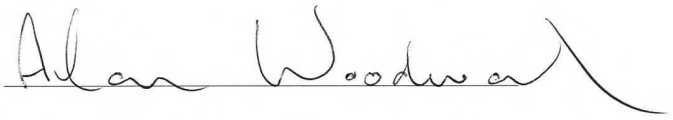
[19] De Leo, D; Heller, T. 2008. Social Modeling in the Transmission of Suicidality. Crisis. Vol 29.

Maple, M; Cerel, J; Sanford, R; Pearce, T; Jordan, J. 2016. Is Exposure to Suicide Beyond Kin Associated With Suicidal Behaviour? Suicide and Life Threatening Behavior.

Hedstrom, P; Lui, K.Y; Nordvik, M.K. 2008. Interaction Domains and Suicide: A Population Based Panel Study of Suicides in Stockholm 1991-1999. Soc Forces. Vol 87.

82 The pivotal point for all services and responses to suicide, however, is the importance of compassion and respectful, non-judgemental support for those individuals who become suicidal for whatever reasons in their lives, and for those who care for them and are impacted by the trauma of a suicidal event or death. Suicide is a profoundly destructive and damaging feature of the human condition.

83 We should not medicalise it, trivialise it or stigmatise it – we should reach out to the people for whom suicide and suicidality has become their reality and seek to address their pain – and at the same time create service systems and communities that work to prevent this pain elevating to the crisis levels where the reasons for dying become greater than the reasons for living – for anyone.

sign here ► 

print name Alan Woodward

date 18 July 2019

Royal Commission into
Victoria's Mental Health System

ATTACHMENT AW-1

This is the attachment marked '**AW-1**' referred to in the witness statement of Alan Woodward dated 18 July 2019.

Alan Woodward

Curriculum Vitae

PERSONAL AND PROFESSIONAL CAPABILITIES

- Expertise in suicide prevention and mental health services and program development
- Policy development, especially social policy – suicide prevention and mental health
- Research and evaluation projects especially through research partnerships
- Service coordination and integration across community and health services
- Strategic analysis, development and implementation of strategic plans
- Performance measurement
- Executive leadership and general management
- Governance, ethics and accountability mechanisms
- Community engagement

ACADEMIC QUALIFICATIONS

Masters of Social Science and Policy Studies University of New South Wales (1998)
- majors in social policy, social research and evaluation

Bachelor of Business Charles Sturt University (1995)
- majors in economics/finance, politics and organisational behaviour/HR management

Diploma in Arts Mitchell College of Advanced Education (1984)
- majors in communication (journalism), literature and theatre arts

CURRENT: PhD Candidate with University of Melbourne, Centre for Mental Health, School of Population and Global Health – research topic: Caller Experiences and Impact of Telephone Helplines.

POSITIONS HELD

Independent Consultant

2018

Alan is currently operating as an independent consultant, specializing in suicide prevention and mental health, drawing on his many years of experience and expertise in these fields.

His consultancy business offers strategic advice, specialist assistance with program design and development, as well as the conduct of evaluations, data monitoring and research translation.

Community engagement and collaborative methods of sharing knowledge and formulating shared action are features of Alan's skill and style in consulting.

Strategic Adviser, Suicide Prevention Australia

2018

Alan provides advice to Suicide Prevention on strategic policy, the operations of the Suicide Prevention Research Fund and on quality and innovation for the Australian suicide prevention sector – through a part-time role he has with the national association Suicide Prevention Australia.

This role includes advising on the development of tools to better map the services and programs across the sector, provide measures and methods for evaluation and ways to encourage continual improvement using quality management techniques.

This work relates to The Best Practice Hub and professional development services for Members Organizations of SPA.

Strategic Leadership and Knowledge Management
Lifeline Australia
2017 - 2018

In June 2017 Alan was appointed as Executive Director Research and Strategy with Lifeline Australia, extending his responsibilities to incorporate the organisation's media, communications, policy advocacy and marketing functions as well as the research and evaluation program of the Lifeline Research Foundation. During this time, Alan contributed to the first collaborative communications campaign on suicide prevention involving seven key mental health organisations and the theme '#youcantalk as well as leading the development of Australia's first rail stations communications campaign under the theme Pause Call Be Heard. Alan contributed heavily to policy achievements on a national suicide prevention implementation plan and on greater focus surrounding crisis response and aftercare for suicidal persons and their carers.

During this time, Alan provided strategic advice to Lifeline Australia on directions for digital service reform and for strengthening the community outreach and supports offered through 40 Lifeline Centres in Australia. He also provided assistance, on invitation, to the Ukraine Health Ministry on helplines services and participated on request to expert exchanges in China and at an ASEAN countries suicide prevention conference.

Prior to his departure from Lifeline Australia in September 2018, Alan appointed two senior managers into communications and research roles respectfully, thereby consolidating the linkages between knowledge, translation and communication/marketing as a core function of Lifeline Australia, complementary to service provision.

Suicide Prevention Research and Evaluation
Lifeline Research Foundation
2011 - 2017

Alan is the Executive Director, Lifeline Research Foundation, and oversaw its establishment in June 2011 and growth in attracting more than $750,000 in corporate and other donations for research. He has established the Expert Advisory Group made up of 12 leading academic and professional experts on mental health and suicide prevention in Australia. Major research work has been undertaken to examine the efficacy of online crisis chat, profile of callers to helplines, suicide awareness programs in schools, and the promotion of crisis support at suicide hot spots. New knowledge has been generated for program development.

The Lifeline Research Foundation has also had a role in policy advice to Government and in policy processes involving those working in suicide prevention, mental health and crisis support. Alan participated in multiple policy forums as a representative of Lifeline Australia and as an expert spokesperson. Recent policy development has included the Digital Mental Health Gateway, and the implications for existing helplines and digital services.

Alan also contributes to international policy and strategy on suicide prevention, as Co-Convener of the IASP Helplines Special Interest Group, and as a member of the World Alliance for Crisis Helplines.

Policy and Program Reform
Lifeline Australia
2004 - 2010

As General Manager National Services, Alan formed and led a team of 10 staff to establish a national program of service reform for the Lifeline 13 11 14 telephone crisis service. The service development program involved identifying areas of major risk and service performance, to shift from a distributed network of individual Lifeline Centres to a national network. The practice model based on this work has defined the evidence base and standards for effective crisis support and suicide prevention.

As General Manager, Social Policy Innovation Research and Evaluation, Alan led a small team of expert advisors on suicide prevention to review and revise the Lifeline Suicide Prevention Strategy and establish a service development program. Alan coordinated the Lifeline submission to the Senate Inquiry into Suicide Prevention and gave evidence formally on two occasions.

Governance Reform
Lifeline Australia
2003 - 2010

Alan supported a program of governance reform for Lifeline Australia and its membership, initially as a consultant and then as the Company Secretary. Alan managed the internal consultation processes and achieved membership acceptance of a package of governance reforms in November 2006. These reforms included Constitutional Reform, formation as a Company Limited by Guarantee, a Governance Charter, revisions to the Lifeline Accreditation and Standards Program and specified internal communication, consultation and decision-making protocols. In effect, the governance reforms created a partnership model for collaborative action involving 24 NGO member organizations of Lifeline Australia, operating 40 community Lifeline Centres.

PAST EMPLOYMENT HISTORY

MANAGER

IMB Community Foundation
1999 – 2004
Wollongong

As the part-time consultant manager for this Foundation, Alan developed, promoted, managed and evaluated its activities. More than $2.2m in funds were distributed over five years to 85 community projects. These projects addressed economic, social, cultural, employment and knowledge outcomes. They involved partnerships between government, business and community.

SENIOR CONSULTANT

Twyford Consulting
1998 – 2004
Wollongong

As one of four consultants in a private consulting practice, provided consulting advice and services on business performance improvement, capacity building and evaluation/review, principally in social policy and the community/health services sectors. Undertook more than 20 program/service reviews in areas such as health, aged & disability services, youth programs, and foster care/family support/counselling. Utilised public participation techniques and advised organisations on strategies and techniques to improve stakeholder relationships.

NSW PUBLIC SERVICE
1985 - 1998

Alan commenced work as a Counter Clerk, base grade at Dubbo Lands Office and progressed to hold senior management positions. His public service career included:

Corporate Manager, Human Resources for Department of Land and Water Conservation; a department of 3,500 people

Personal Staff, Director-General of Land and Water Conservation

Office of Public Management, providing advice on 'whole of government' program delivery in the natural resources sector

Independent Commission Against Corruption, establishing the Education Program for the Commission

Institute of Public Administration Australia – conduct of a national ethics project and developed a Charter of Public Service Ethics.

Office on Ageing – policy and program roles

Department of Housing – crisis housing roles, education and training roles

PROFESSIONAL ASSOCIATIONS

- NSW Mental Health Commission Community Advisory Council member 2015 - present
- Co-Chair – Helplines Special Interest Group, International Association for Suicide Prevention 2010 - present
- President, Australasian Evaluation Society (AES) 2010 – 2012; Board Director, Australasian Evaluation Society 2008 – 2010 (NB: Alan remains a member of the AES)
- Board Director, Suicide Prevention Australia 2009 – 2018 (three elected terms)

NB: Appointed to National Mental Health Commission Advisory Board – commencing August 2019

PROFESSIONAL CONTRIBUTIONS (RECENT)

- Expert Advisory Group, Evaluation Framework, - Centre of Best Practice in Aboriginal and Torres Strait Islander Suicide Prevention – 2018 (current)
- National Suicide Prevention Trials Evaluation Steering Committee, Department of Health – 2018 (current)
- NSW Ministerial Suicide Prevention Advisory Committee 2012 - present
- MindSpot Expert Advisory Group – 2016 – present
- Research Review Group, UK Samaritans, on helpline callers research – 2017 and 2018.
- RUOK? Day Scientific Advisory Group 2012 - 2017
- Woollahra Council Stakeholders Group – Gap Park 2010 – 2015
- Trauma Informed Care Advisory Group (Mental Health Coordinating Council) 2013
- Centrelink/Department of Human Services Mental Health Working Group 2011-2012
- eMental Health Advisory Committee, Department of Health & Ageing 2008/9
- Mental Health and Homelessness Working Group, Mental Health Australia 2008
- TeleWeb Quality Standards Working Group, Department of Health and Ageing 2007
- Panel Judge, Local Government Awards (Community Development section) – 2004 - 2006