I, Jane Pirkis, Professor, of 207-221 Grattan Street, Parkville Victoria, 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.

Current and previous roles

2 I am currently the Director of the Centre for Mental Health, in the Melbourne School of Population and Global Health, at the University of Melbourne. I have held this role since September 2013.

3 Prior to my current position, I have held several roles at the University of Melbourne since 1994 including:

(a) Professor (October 2009 – August 2013) and Director (January 2009 – August 2013) of the Centre for Health Policy, Programs and Economics, Melbourne School of Population Health;

(b) Associate Professor (January 2004 – September 2009) and Assistant Director (February 1996 – December 2008), Centre for Health Policy, Programs and Economics, Melbourne School of Population Health, University of Melbourne; and

(c) Senior Research Fellow (February 1994 – December 2003), Centre for Health Policy, Programs and Economics, Melbourne School of Population Health, University of Melbourne.

4 I have also held the following positions:

(a) Harkness Fellow in Health Care Policy, Division of Adolescent Medicine, University of California at San Francisco (September 2001 – August 2002);

(b) Project Consultant, Mental Health Classification and Service Costs Project (July 1995 – October 1997);

(c) Research Officer, Springvale Community Health Centre (March 1993 – January 1994);

(d) Policy Analyst, National Health Strategy (May 1992 – February 1993);
(e) Policy Analyst/Project Officer, Drug and Alcohol Directorate and Government Relations Branch, New South Wales Department of Health (September 1990 – April 1292);

(f) Research Assistant, Department of Public Health, University of Sydney (January 1990 – August 1990);

(g) Educational Psychologist, Tasmanian Education Department (February 1988 – December 1988); and

(h) Tutor, Psychology Department, University of Tasmania (February 1987 – December 1987).

Background and qualifications

5 My background is in psychology and epidemiology, with a focus on mental health and suicide prevention at the population level.

6 I hold the following relevant qualifications:

(a) Doctor of Philosophy from the University of Melbourne (2001);

(b) Master of Applied Epidemiology from the Australian National University (1995);

(c) Master of Psychology (Clinical) from the University of Tasmania (1988); and

(d) Bachelor of Arts (First Class Honours in Psychology) from the University of Tasmania (1985).

7 I completed my PhD on the epidemiology of suicide and suicidal behaviour.

8 I have authored more than 300 peer-reviewed journal articles on mental illness, suicide and suicide prevention which have been published between 1992 and 2019.

9 Attached to this statement and marked “JP-1” is a copy of my Curriculum Vitae, which sets out further details of my career to date, and identifies some of my recent publications.

Rates of and risk factors for suicide

10 In Victoria in 2017 (the year for which the most recent suicide statistics are available) the overall suicide rate was 9.6 per 100,000 (14.0 per 100,000 for males; 5.4 per 100,000 for females). This placed it lower than the national average (12.6 per 100,000 persons, 19.1 per 100,000 males; 6.2 per 100,000 females).

11 Risk factors are characteristics or attributes of individuals, or things that they may have been exposed to, that increase the likelihood of their dying by suicide.
Risk factors can be classified as:

(a) **Socio-demographic** – e.g., males are at greater risk of suicide than females.

(b) **Clinical** – e.g., having a mental illness or having made a previous suicide attempt confers risk for suicide.

(c) **Personality-based** – e.g., impulsivity and aggression have been shown to increase suicide risk, as has poor problem-solving skills.

(d) **Situational/environmental** – e.g., experiencing stressful life events can heighten suicide risk, as can having access to lethal means.

(e) **Genetic** – e.g., a family history of suicide can increase an individual’s own risk.

(f) **Neurobiological** – e.g., low levels of serotonin have been shown to be associated with suicide.

Suicide prevention experts often distinguish between proximal and distal risk factors. Risk factors that occur close to the suicide are proximal and those that present well before the event are distal. There is interaction between these; distal risk factors (for example, a history of mental illness) set the potential for suicidal behaviour and proximal risk factors (for example, recent stressful life events) act as a catalyst by which the potential is achieved.

Different terms are sometimes used synonymously with risk factors, like “stressors”, “triggers” and “tipping points”. However, these terms typically apply to proximal risk factors rather than distal ones.

Having a mental illness and having made a previous suicide attempt are both widely accepted as conferring significant risk for suicide.¹

One of my PhD students, Angela Clapperton, recently conducted a study to identify factors that were over-represented in Victorians who died by suicide in 2013 compared with the general population.² I co-supervised that study. Angela found that having a mental illness was associated with increased suicide risk, as was having drug and alcohol problems, and that this held true for males and females and across age groups.

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She found some more immediate stressful life events were also associated with suicide risk, notably trouble with the police.

However, it is important to remember that risk factors are about probabilities, not certainties. Obviously, for example, many people with mental illness do not die by suicide and not all of those who die by suicide have a mental illness.

In a second study, Angela looked at all suicides occurring in Victoria between 2009 and 2013 and found that in 52% of cases there was evidence that the person had a mental illness. She examined records relating to individuals with a documented diagnosed mental illness and individuals whose records did not indicate a diagnosis more closely and identified further sub-groups.

Angela found that the people with and without mental illness who died by suicide had multiple different immediate stressors recorded as present at the time of their death. These stressors could be grouped into personal (e.g., sexuality, isolation, experience of abuse), interpersonal (e.g., conflicts with partners, family members and non-family members), physical (e.g., illness, injury and pain), situational (e.g., work, financial, legal, education, bullying, substance related), and exposure to suicide (e.g., of a family member). Often individuals experienced a number of stressors simultaneously.

The most common stressor both for people with and without a recorded diagnosed mental illness who died by suicide was drug and alcohol use. Other common stressors identified in the study included separation from and/or conflict with a partner, other family conflict, current treatment for a physical condition, and stressors related to work, finances and legal issues.

Angela’s work shows that suicidal behaviour is related to but also distinct from mental illness. Mental illness heightens the risk of dying by suicide, but there are a range of other factors that increase the risk of suicide, including immediate / proximal stressors that may be present both for those who have a mental illness and those who do not. I believe Angela’s work was novel in that it considered how risk factors impact both people with and people without diagnosed mental illness who had died of suicide within one study. Most studies that I am aware of which have examined suicide risk factors have tended to either consider the general population, or have focused on people with known mental illnesses.

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Suicide prevention

22 “Suicide prevention” includes both the prevention of deaths by suicide and the prevention of suicidal behaviour such as attempted suicide and suicidal thoughts.

23 Suicide prevention initiatives generally fall into three main categories, namely:

(a) **Universal interventions** which target whole populations and focus on particular risk factors without identifying specific individuals with those risk factors. They are often designed to modify the environment by, for example, restricting access to the means of suicide.

Examples include installing barriers on bridges or cliffs where jumping suicides occur or encouraging responsible media reporting (e.g., by disseminating guidelines for journalists to encourage them to report in a way that minimises the likelihood of copycat acts).

(b) **Selective interventions** which target people in the population who are not actively suicidal, but who have recognised risk factors for suicidal thoughts and behaviours (e.g., mental illness).

Some selective interventions target these people directly (e.g., pharmacological treatments like antidepressants and lithium), others aim to better equip health professionals to detect, diagnose and manage mental health problems, and still others teach frontline workers and other professionals who come into regular contact with at-risk individuals how to identify them and refer them to appropriate services (e.g., ‘gatekeeper training’).

(c) **Indicated interventions** which target individuals who are already having suicidal thoughts or engaging in suicidal behaviour. These people are typically identified through screening programs or by presenting to a clinical service.

Indicated interventions include psychological therapies and ongoing support and communication. Ongoing support and communication can take various forms. It may involve providing follow-up appointments with community-based services once a person has been discharged from an emergency department, or it may involve emergency department or other clinical staff sending postcards or text messages to maintain a connection with the person.

Is suicide preventable?

24 It is my firm belief that suicide is preventable, but there is still a lot that we do not know about what works and what does not work in suicide prevention. There are many reasons for this.
One key reason is that suicide is extremely complex. There are often multiple reasons that lead a person to decide that ending his or her life is their only choice; it is relatively uncommon for a single cause to lead a person to this point.

As I noted above, it is possible to identify particular risk factors that are associated with suicide at a population level. The difficulty is that none of these risk factors are sensitive or specific enough to allow us to predict which individuals will die by suicide. This reflects the fact that risk factors give rise to an increased likelihood of suicide, not absolute certainty.

For these reasons, I consider it important to think about risk factors at a population level, and to seek to mitigate risk through a combination of universal, selective and indicated interventions. Trying to predict the likelihood that certain individuals will attempt suicide based on their risk factor profile is unlikely to be helpful, however, as there would be many false positives and false negatives.

It should also be noted that research and evaluation in the suicide prevention field faces a number of challenges and limitations, and consequently our knowledge of which interventions are effective is more limited than is desirable. There are several reasons why suicide prevention research is hard to conduct:

(a) Studies in suicide prevention often involve vulnerable participants who are struggling with many challenges. There is a real need to protect these participants and make sure that their involvement in research does not cause them any harm. In practice, however, this means that suicidal individuals are actively excluded from intervention studies, so we remain uncertain about the effectiveness of interventions in relation to the very people that might benefit most from them.

(b) Although suicide is a major public health problem and each and every suicide is tragic, individual suicides are, fortunately, relatively rare events. This means that it is often difficult to demonstrate that a particular intervention has averted a significant number of suicides. In order to demonstrate this, studies would require prohibitively large sample sizes.

(c) It is often difficult to conduct rigorous evaluation studies in suicide prevention. Significantly, many suicide prevention interventions (particularly universal interventions) are not amenable to evaluation by randomised control trials, which are often regarded as the ‘gold standard’ in demonstrating evidence of effectiveness. For example, it is not feasible to randomly assign safety barriers to certain bridges but not others.
Global best practice on suicide prevention

29 No country has managed to entirely prevent suicide. Also, international comparisons can be difficult because suicide data varies in quality across countries. Nonetheless, there is value in looking to other countries for effective suicide prevention approaches.

30 Although evidence is accumulating about the effectiveness of various components of a suicide prevention response, for the reasons I have stated above, current knowledge of what works in suicide prevention is quite limited and fragmented.

31 In practice, this has meant that many countries have put in place a range of universal, selective and indicated interventions. In recent times, bodies like the World Health Organization (WHO) have called for these efforts to be better coordinated, both at the national level and the local (or community) level.¹

32 A number of countries have national suicide prevention strategies in place which call for a mix of interventions. The WHO has provided guidance as to the types of suicide prevention strategies that may be useful, listing them as follows:

(a) surveillance of suicides and suicide attempts;
(b) restricting access to means of suicide;
(c) promoting responsible media reporting of suicide;
(d) increasing access to services;
(e) providing training and education for identified ‘gatekeepers’ (e.g., health workers, teachers, police);
(f) improving the quality of clinical care;
(g) providing access to crisis intervention;
(h) offering postvention (i.e., responses for those affected by suicide and suicide attempts); raising community awareness about suicide;
(i) reducing stigma and discrimination; and
(j) providing oversight and coordination.

33 At the local level, the call for a coordinated approach has resulted in better integration and organisation of multiple suicide prevention efforts in what has become known as a systems-based approach.

34 In Australia, the best example of a systems-based approach is LifeSpan. LifeSpan was developed by the Black Dog Institute and is being tested in a number of Primary Health

Networks in national and state-based trials. LifeSpan involves the following interventions, tailored to local community need:

(a) improving emergency and follow-up care for suicide crises;
(b) using evidence-based treatment for suicidality;
(c) equipping primary care to identify and support people in distress;
(d) improving the competency and confidence of frontline workers to deal with suicidal crises;
(e) promoting help-seeking, mental health and resilience in schools;
(f) training the community to recognise and respond to suicidality;
(g) engaging the community and providing opportunities to be part of change;
(h) encouraging safe and purposeful media reporting;
(i) improving safety; and
(j) reducing access to means of suicide.

Restricting access to means

In relation to individual interventions, some of the best practices which are being implemented internationally are also being used in Australia. A recent systematic review by Gil Zalsman and colleagues suggested that there is strong evidence for restricting access to means, school-based awareness programs and particular psychological therapies (for example, cognitive behavioural therapy).

Out of the practices identified in Zalsman’s review, I am most familiar restricting access to means of suicide. These practices have shown evidence of effectiveness both in Australia and internationally. For example, changing the packaging of paracetamol (introducing blister packs and selling smaller quantities in a single pack) has been shown to significantly reduce paracetamol poisoning suicides. Installing catalytic converters on motor vehicles has led to decreases in suicides by carbon monoxide poisoning. Also, installing barriers on bridges and cliffs that have developed reputations

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5 Zalsman G. et al, ‘Suicide prevention strategies revisited: 10-year systematic review’ (July 2016) 3.7 Lancet Psychiatry. DOI: 10.1016/S2215-0366(16)30030-X.
as ‘suicide hotspots’ has resulted in major reductions in jumping suicides from these sites.\(^8\)

37 Suicide prevention experts have theorised that restricting access to means works because it stops the person’s suicidal behaviour and creates time for them to rethink their actions and/or gives others time to intervene.\(^9\) As an extension of this proposition, people contend that restricting access to means is most likely to work in the case of so-called ‘impulsive suicides’. However, I believe that that the impact of these practices may be more far-reaching and can prevent other types of suicidal behaviour. As I have said, suicide is extremely complex, and a lot of people experience ambivalence about the decision. Restricting access to means at the right point in a person’s thought processes could save their life.

38 The impact of practices that restrict access to means is most readily observed where the particular means accounts for a high proportion of all suicide deaths. For example, pesticide poisoning is the single most common method of suicide worldwide, and in countries where particular highly toxic pesticides have been banned there have been discernible reductions not only in suicides by pesticide ingestion but also in the overall suicide rate.\(^10\)

39 It would be optimal if we could also identify that there has been no substitution of other means and that there is a resulting net reduction in the overall suicide rate. It is not always possible to conduct this sort of analysis, however, due to the challenges and limitations that I have outlined above). For these reasons, evaluations of this nature often require novel and multifaceted approaches (e.g., pooling data from several studies and assessing additional outcomes like suicide attempts).

**How does Victoria’s framework compare to global best practice?**

40 The challenges faced at a global level are reflected in Australia.

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However, there are some positives. For example, Australia was one of the first countries to implement a National Prevention Suicide Strategy, with a cohesive national framework.\(^\text{11}\)

We are also extremely well regarded internationally for the way our guidelines on media reporting of suicide (known as Mindframe) have been developed and rolled out.\(^\text{12}\) There is very strong evidence that irresponsible media reporting of suicide (e.g., reporting that sensationalises suicide or describes a suicide method in detail) can lead to ‘copycat’ acts, and the Mindframe guidelines have unequivocally improved reporting on suicide.\(^\text{13}\)

All states and territories also face challenges. Victoria is attempting to implement ‘best practices’ as much as any other jurisdiction. The ‘Victorian Suicide Prevention Framework 2016-25’\(^\text{14}\) (Framework) recommends a series of preventive approaches under the objectives ‘Build resilience’, ‘Support vulnerable people’ and ‘Care for the suicidal person’, which equate to universal, selective and indicated interventions, respectively.

The Framework also calls for a systems-based approach, under the objective ‘Help local communities prevent suicide’. This latter objective has been operationalised in the Place-Based Suicide Prevention Trial which involves 12 sites delivering LifeSpan strategies in six PHNs. The Place-Based Suicide Prevention Trial is undergoing an independent evaluation.

Importantly, the Framework recognises that there is still much to be learned about what works and what doesn’t work in suicide prevention, so it also calls for evaluation of suicide under the objective ‘Learn what works best’.

**Recommendations**

For the reasons I have mentioned above, it is difficult to predict suicide at the individual level. It is particularly difficult in clinical settings where most people have the most common risk factor (namely, mental illness) but will not necessarily attempt suicide.

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Consequently, indicated and selective interventions in these settings need to be complemented by universal approaches.

47 Universal, preventive efforts at an “upstream” population level may reduce the “downstream” burden on clinical services.

Importantly, universal measures will also ensure that suicide prevention measures reach those in the population who do not have a mental illness but may face adversity in the form of, for example, unemployment, lack of education or problems with the law. Universal measures which could be effective in reaching these people would involve targeting non-clinical risk factors, including situational and environmental ones. This would require the mental health and suicide prevention sectors to work with sectors outside health, like employment, education and justice.

48 For the reasons already outlined above, one universal intervention that requires special consideration is restricting access to means. We should capitalise on this strategy, given that the evidence of its effectiveness is strong. Securing suicide hotspots is one example of this but there are others (e.g., regulation of poisons and other substances that are lethal in overdose).

49 Clinical mental health services need to be able to help all consumers achieve their best possible mental health, not just individuals who have shown signs of suicidal behaviour. To achieve this, we need to provide optimal conditions for staff working in the mental health system. Expanding the workforce (e.g., including peer workers), providing staff with support and better equipping staff to provide effective care for all consumers could have a major impact.

50 We also need to invest in strengthening the evidence base regarding what works (and what doesn't work) in suicide prevention. To gather this evidence, we need to prioritise rigorous suicide prevention research. We need to devise ways to safely testing interventions in a way that allows us to determine whether they work for those who are actively suicidal. We should also foster Australian and international collaborations to mount large-scale, multi-site studies to provide sufficiently large samples.

51 Having said this, we cannot wait until we have perfect evidence; we must do the best that we can based on the information available.

52 As a part of this, promising novel interventions should be trialled and implemented, even if there are gaps in the evidence base. However, to do this safely and measure the effectiveness of these strategies, there is an onus on those who are funding and delivering them to conduct meaningful evaluations as they are rolled out.
sign here ▶

[Signature]

print name Jane Pirkis

date 18 July 2019
ATTACHMENT JP-1

This is the attachment marked ‘JP-1’ referred to in the witness statement of Jane Pirkis dated 18 July 2019.
Curriculum Vitae

PERSONAL DETAILS

Name: Professor Jane Elizabeth PIRKIS

Addresses:
Centre for Mental Health
Melbourne School of Population and Global Health
University of Melbourne
Victoria 3010
AUSTRALIA

EDUCATION

2001: Doctor of Philosophy
University of Melbourne

1995: Master of Applied Epidemiology
Australian National University

1988: Master of Psychology (Clinical)
University of Tasmania

1985: Bachelor of Arts (First Class Honours in Psychology)
University of Tasmania

EMPLOYMENT HISTORY

Feb 94 – current: Professor and Director (Sept 2013 – current), Centre for Mental Health, Melbourne School of Population and Global Health, University of Melbourne; Professor (Oct 2009 – Aug 13) and Director (Jan 2009 – Aug 2013), Centre for Health Policy, Programs and Economics, Melbourne School of Population Health, University of Melbourne; Associate Professor (Jan 2004 – Sept 2009) and Assistant Director (Feb 1996 – Dec 2008), Centre for Health Policy, Programs and Economics, Melbourne School of Population Health, University of Melbourne; Senior Research Fellow (Feb 1994 – Dec 2003), Centre for Health Policy, Programs and Economics, Melbourne School of Population Health, University of Melbourne

Sept 01 – Aug 02: Harkness Fellow in Health Care Policy, Division of Adolescent Medicine, University of California at San Francisco

Jul 95 – Oct 97: Project Consultant, Mental Health Classification and Service Costs Project

Mar 93 – Jan 94: Research Officer, Springvale Community Health Centre

May 92 – Feb 93: Policy Analyst, National Health Strategy

Professor Jane Pirkis
Sept 90 – Apr 92    Policy Analyst/Project Officer, Drug and Alcohol Directorate and Government Relations Branch, New South Wales Department of Health
Jan 90 – Aug 90    Research Assistant, Department of Public Health, University of Sydney
Feb 88 – Dec 88    Educational Psychologist, Tasmanian Education Department
Feb 87 – Dec 87    Tutor, Psychology Department, University of Tasmania

FELLOWSHIPS/SCHOLARSHIPS
2014    Senior Research Fellowship, Level B (National Health and Medical Research Council)
2009    Senior Research Fellowship, Level A (National Health and Medical Research Council)
2003    Career Development Award (National Health and Medical Research Council)
2001    Harkness Fellowship in Health Care Policy (The Commonwealth Fund)
1994    General Practice Evaluation Program Scholarship (Commonwealth of Australia)
1986    Post-Graduate Research Scholarship (Commonwealth of Australia)

AWARDS/PRIZES
2017    Distinguished Alumni Award (University of Tasmania)
2013    Senior Research Paper Award (Centre of Research Excellence in Suicide Prevention)
2010    Lifetime Research LIFE Award (Suicide Prevention Australia)
2009    Award for Excellence in Evaluation (Australasian Evaluation Society)
2008    Referees’ Choice Award (Australian and New Zealand Communication Association Conference)
2004    Early Career Award for Excellence in Research Achievement (School of Population Health, University of Melbourne)
PUBLICATIONS (LAST 10 YEARS ONLY)

Publications in peer-reviewed journals


Professor Jane Pirkis


90. Nicholas A, Day S, Pirkis J, Harvey C. (2016). Mental health professional online development (MHPOS): Pilot testing of an online training package for Australian specialist mental health services. Focus on Health Professional Education. 17, 2.


144. Machlin A, Pirkis J, Spittal M. (2013). Which suicides are reported in the media, and what makes them 'newsworthy'? Crisis, 34, 305-313.


Professor Jane Pirkis


Books


Book chapters/sections


PRESENTATIONS AT SCIENTIFIC CONFERENCES (LAST 10 YEARS ONLY)


7. Pirkis J. (2018). Attracting funding for suicide prevention research. Invited masterclass delivered to the International Association for Suicide Prevention’s 8th Asia Pacific Regional Conference, Bay of Islands, New Zealand, 2-5 May.

8. Pirkis J. (2018). Restricting access to means of suicide and self-harm. Presentation to the International Association for Suicide Prevention’s 8th Asia Pacific Regional Conference, Bay of Islands, New Zealand, 2-5 May.
9. Pirkis J. (2018). Outcomes of community-based suicide prevention approaches which aim to reduce access to pesticides. Invited presentation to the International Association for Suicide Prevention’s 8th Asia Pacific Regional Conference, Bay of Islands, New Zealand, 2-5 May.


22. Pirkis J. (2015). Interventions to prevent suicides by young people and adults at known suicide ‘hotspots’. Invited presentation to the International Association for Suicide Prevention 2nd Caribbean Regional Symposium, Cayman Islands, 3-4 December.


28. Pirkis J. (2014). Meeting the needs of suicidal individuals who make frequent and/or repeat calls to helplines. Paper presented to the International Association for Suicide Prevention World Congress, Montreal, 16-20 June.


43. Pirkis J (2013). Suicide and the Internet: The good, the bad and the Google-y. Plenary paper presented to the International Academy for Suicide Research World Congress on Suicide, Montreal, 10-13 June.

44. Pirkis J (2013). Improving access to psychotherapy delivered through primary care: The Australian experience. Paper presented to the International Academy for Suicide Research World Congress on Suicide, Montreal, 10-13 June.


**GRANTS (LAST 10 YEARS ONLY)**

2019

2018

2018

2018

2017

2017
Austrian Science Fund (FWF). Suicide prevention public service announcements (PSAs) targeting adolescents: A randomized controlled trial. (Chief Investigators: Niederkrotenthaler T, Till B, Pirkis J).

2017

2017

2017


2016 Public Transport Victoria. Literature review, survey design and analysis of results relating to the Community Stations project. (Chief Investigators: Pirkis J, Spittal M, Reavley N, Too T).


2010  Victorian Department of Health: Mental Health Professionals Online Development (MH-POD) pilot. (Chief Investigators: Pirkis J, Day S).


2009  National Health and Medical Research Council: Senior Research Fellowship. (Chief Investigator: Pirkis J).

PROFESSIONAL MEMBERSHIPS (LAST 10 YEARS ONLY)

2017-current  Member, Academy of the Social Sciences in Australia

2014-current  Member, International Academy of Suicide Research

2009-2012  Member, Australian Society for Psychiatric Research

2006-current  Member (2006-current) and Board Member (2006-2008), Suicide Prevention Australia

2005-current  Vice President (2017-current), General Secretary (2013-2017), Australian Representative (2007-2014), Chair, Suicide and the Media Task Force (2005-2010), International Association for Suicide Prevention

2000-current  Member, Australian Psychological Society

2000-current  Registered Psychologist, Victorian Psychologists’ Registration Board

2000-current  Member (2000-current) and Executive Member (2004-2009), Australian and New Zealand Health Services Research Association

APPOINTMENTS AND ADVISORY ROLES (LAST 10 YEARS ONLY)

2018-current  Member, Technical Advisory Group for the Development of the Third National Adult Survey of Mental Health and Wellbeing (appointed by Department of Health)

2017-current  Member, Suicide Prevention Project Reference Group (established by the AMHAC Mental Health Principal Committee)

2017-current  Vice President, International Association for Suicide Prevention

2016-current  Member, Expert Panel on Suicide Prevention (appointed Department of Health)

2016-2018  Member, Australian Advisory Group on Suicide Prevention (appointed by National Mental Health Commission)

2015  Member, Mental Health Expert Reference Group (appointed by Department of Health to advise on response to National Mental Health Commission’s review of mental health programs and services)

2013-2015  Member, Australian Suicide Prevention Advisory Council (Ministerial appointment)

2012-current  Member, Lifeline Foundation Expert Advisory Group (appointed by Lifeline Foundation)
2012-current  Member, R U OK? Scientific Advisory Group (appointed by R U OK?)
2012-current  Member, Oxygen Research Committee (appointed by Oxygen)
2012-2016  General Secretary, International Association for Suicide Prevention
2005-2014  Australian National Representative, International Association for Suicide Prevention

REFEREE/REVIEWER SERVICES (LAST 10 YEARS ONLY)
2004-current  Assessor, Grant Review Panel Member and/or Assigners Academy member, National Health and Medical Research Council
2004-current  Member, Australian Rotary Health Research Committee

OTHER PROFESSIONAL SERVICES (LAST 10 YEARS ONLY)
2018-current  Editor-in-Chief, CRISIS
2009-current  Member, Editorial Board, International Journal of Mental Health Systems
2005-2017  Member, Editorial Board, CRISIS
2011-current  Member, Organising Committee, International Association for Suicide Prevention International Congresses and Asia/Pacific Conferences

Professor Jane Pirkis