Preventing suicide:

What works in suicide prevention?

Leanne, New South Wales

I have been living with depression, panic anxiety disorder, PTSD and agoraphobia for many years. I have five adult children and lived with a lot of domestic violence in my two marriages. I live with my 22 year-old son. He gave up his navy career at 18 to become my full-time carer after I attempted suicide and ended up in intensive care. I have tried to take my life numerous times.

I was an only child and my father remarried after Mum passed away when I was aged 12. I experienced lots of domestic violence from my stepmother and we never stayed in one place for too long so it was hard to hold on to friends.

I recently attempted suicide again but my son saw the warning signs and called the police. The ambulance staff were very helpful and stayed until I got a hospital bed.

My psychologist arranged for me to have a support worker which has made such a difference to my life. We have set meaningful goals, including improving the quality of my life, being able to get out into the community a little more and able to ask for help when needed.

I am an Indigenous Australian and have traced my heritage to the Noongar people of Western Australia. I would love to get rid of the stigma of mental illness and suicide because I know what it is like to be called a ‘crazy woman’ and labelled a ‘wacko’.

The courts recommended I participate in an Indigenous Elders meeting for mediation relating to domestic violence issues. I wasn’t aware of specific Indigenous services, but it’s been an amazing experience, helping me with a lot of my issues.

My children are the first people to be there for me, then my psychologist, GP and my support worker. I’ve come ahead in leaps and bounds in the last two months and my support person is helping me to see things in a positive light.

Watch Leanne’s video at www.mentalhealthcommission.gov.au
If suicide was a disease, funds would be scrambled and urgent searches started to find vaccines, causes and cures.

No part of our community is immune; suicide kills more young people than anything else and kills three times more men than women. The suicide rate is highest in those aged over 85.21

Suicide takes one and a half times as many Australian lives each year as road accidents.22 Road accident deaths have substantially reduced in recent decades, but over the same period there has not been the same level of reduction in suicide rates. We can and must do better than this.

We all know that drink driving increases our risk of dying on the road and discussing who will be the designated driver is often part of a night out. We need the same openness with our other conversations. Talking about difficult emotions – even if we notice someone isn’t coping – does not come easily to many of us, and suicide is still often a taboo subject.

Every death by suicide expresses unimaginable anguish, and it happens on average six times every day in Australia.23 In 2007 over 65,000 people reported attempting to take their own life.47 Most of these attempts do not come out of nowhere. Many of these 65,000 people would not live their life in isolation – they may attend school or work (or fail to turn up), talk with friends or family, visit their GP or Centrelink – or they may simply ‘fall off the radar’. In our 2012 Report Card we called for more timely support for those who may be contemplating suicide, and more rapid and local reporting of suicidal behaviour. We repeat this call, and will continue to do so as long as there is no visible action and preventable suicides continue to occur.

This year we focus on what can drive down our suicide rate and the number of suicide attempts each year. We highlight where our knowledge is lacking in what works best for the community as a whole, and for groups who are more vulnerable to suicide. We look at the geographic, social and economic inequality of the burden of suicide across our communities and shine a light on the troubling level of suicide attempts.

We know that each year in Australia, more than 2,200 people die by suicide, and that an overwhelming three quarters of these are men.21 The decade between 2002 and 2011 saw a 15.3 per cent reduction in suicides, mostly due to a substantial reduction in high levels of deaths among young men.21 Declines across all groups appear to have stalled in the last few years. Recent changes in data collection methods and review may have contributed to this picture, but it is clear that rates remain too high.

We know that suicide arises from a complex interaction of many vulnerabilities, triggers and factors in a person’s life.244 However, suicide is not just an individual act. Social and economic circumstances and differences between cultures also contribute.245 We know this because it hits our disadvantaged and marginalised communities the hardest, reflecting wider social, geographic and economic inequalities as well as everyday discrimination and exclusion.

In our consultations the Commission has been made aware of how suicide affects people in their communities – those at higher risk of suicide include Aboriginal and Torres Strait Islander peoples; those who identify as lesbian, gay, bisexual, transgender or intersex (LGBTI); those experiencing chronic physical pain or illness; some Armed Forces veterans; men who live in rural or remote areas; and people experiencing mental illness.
Aboriginal and Torres Strait Islander people who die by suicide are half as likely as other Australians to have ever received help for a mental health problem. But they are twice as likely as non-Indigenous people to take their own lives.

The suicide burden falls disproportionately on young Aboriginal and Torres Strait Islander men and women – where those aged between 15 and 19 years die by suicide at 4.4 and 5.9 times the rates of other young Australians respectively.

There are stark geographical inequalities in suicide rates which this year we show for the first time. Rates are more than twice as high in the Northern Territory (20.0 per 100,000) as in New South Wales and Victoria (8.5 and 9.5 per 100,000 respectively). The map of suicide deaths in Australia at Figure 15 shows this regional variation for the period 2007-2011, with darker colours indicating a higher rate of deaths. People living in non-metropolitan areas are more likely to die by suicide than those living in capital cities, and we know that men not living in major cities are almost twice as likely as their urban counterparts to die by suicide.
Suicidal thinking, plans and attempts among the LGBTI community are shockingly high. People who identified as lesbian, gay or bisexual reported suicidal thoughts during their lifetime at almost three times the rate of those identifying as straight, and suicidal plans or attempts during their lifetime at four times the rate.  

Experiencing **chronic pain or illness** are also related to risk for suicide. Recent research in the UK has found that ten per cent of people completing suicide were suffering chronic illness. In ‘battling’ the physical illness a person’s emotional wellbeing can be overlooked by family, friends and their treating health professionals; for example, as many as 70 per cent of those diagnosed with cancer think about suicide during the three months after diagnosis.

Due to actual experiences of discrimination and an expectation of discrimination by lesbian, gay, bisexual, transgender and intersex people (LGBTI), suicide and thoughts of suicide are a high risk.”  

Susan Ditter, Working It Out Tasmania

Figure 16: Suicidal ideation and behaviours in lifetime by Sex and Sexual orientation

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Source: ABS. Analysis of 2007 NSMHWB (Unpublished)
Caring for a returned serviceman

What it means for Melanie, New South Wales

I have been married for 14 years and have two children. My husband was in the RAAF for almost 15 years, and was deployed to Iraq during the Second Gulf War in 2003.

He returned to Australia for a one-week break and I could tell something was not right. After he returned from his second deployment, his whole psyche had changed. He had been debriefed about Post Traumatic Stress Disorder and I encouraged him to see the psychiatrist at the Base Hospital who recognised the symptoms.

One year later, my husband discharged himself; we left the Defence family and had our second child. This was the most difficult time of our lives, with no stable home or income, a newborn baby and a toddler.

My husband continued to deny his PTSD symptoms. I called the VVCS (Veterans and Veterans’ Families Counselling Services) Hotline and organised counselling. I learnt to take care of myself and knew that the stress my husband put me under was not right.

I hit emotional burnout 4 years into caring. I had to change. I did a couple of courses through Carers NSW which changed my life. I enforced a short separation from my husband. However, I knew that without me as an effective carer, he was at a greater risk of suicide.

I invited my husband back to the house, after working out some much needed boundaries.

Since then I have learnt to look after myself and express when I need a break.

I went back to study, deliberately relying more on my husband. This was good as it increased his capacity to be a part of the family.

I now work part-time and study one postgraduate subject. I am supported by our community, and also by the Partners of Veterans Association (PVA). They understand what it’s like when you need to get away.

Watch Melanie’s video at www.mentalhealthcommission.gov.au
Joining up local interventions across agency and service boundaries seems key to effective prevention. The Baerum suicide prevention team in Norway achieves effective community follow-up after discharge from hospital after a suicide attempt through a model called ‘chain-of-care’. Such a model of joined-up support could be extended to alcohol, primary care and other services to encourage them to collaborate in helping those vulnerable to suicide.

For those communities more vulnerable to suicide, targeted interventions are needed. We can see the importance of such a tailored approach which is designed by and for – community members when we look more closely into what is known about effective approaches for suicide prevention among Aboriginal and Torres Strait Islander peoples.

What the evidence shows is good practice

There is surprisingly little evidence about what works in suicide prevention.

A message is emerging from recent reviews of research: there is an overall lack of evidence, but there are a handful of effective single interventions to reduce the risk of suicide. These interventions can be divided into those aimed at the whole population (universal); those aimed at ‘at-risk groups’ (targeted); and those for people experiencing mental health problems.

We are encouraged that initiatives funded under the National Suicide Prevention Program are being evaluated, and this will provide us with much-needed Australian evidence about effective approaches. In the meantime we know that there are several examples of international best practice in this country.

Our literature review of international and Australian research published in the last three years shows that the most effective programs are those which are comprehensive and systemic and which incorporate multiple but co-ordinated approaches and interventions. However, there is as yet little knowledge about how different elements of these systemic approaches interact with each other, how they might be best integrated, nor about how different combinations of approaches work in different settings.

A good suicide prevention approach is not just, or even mainly, about mental health services. Many other agencies and places – Centrelink, homeless shelters, schools and colleges, and workplaces – are far more likely to come into contact with people who are suicidal. In a Queensland study, 63 per cent of those who have survived a suicide attempt report that they have not attended any mental health service or professional. Preventing suicide requires action at all levels of government (to plan, prioritise resources, and co-ordinate), services (to identify and target those most at risk), and communities (to drive ‘grassroots’ responses).

The European Alliance against Depression, active in 17 European countries, is one example of a multi-component intervention which has had a positive impact on suicidal behaviour (but less impact on suicide rates). The four main components are: GP education, public relations activity, training of community facilitators and interventions targeted at high-risk groups. Grassroots community networks and community capacity building in suicide prevention deliver this approach. However, there is as yet little knowledge about how different elements of these systemic approaches interact with each other, how they might be best integrated, nor about how different combinations of approaches work in different settings.

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“Support when my dad suicided and support being a carer would have made a huge difference. I was unwell myself and had to care for my children and my very unwell mum.”
The heavy suicide burden carried by Aboriginal and Torres Strait Islander communities is a national shame, and one that impacts across generations.

Australia’s first National Aboriginal and Torres Strait Islander Suicide Prevention Strategy was released in May 2013. It was underpinned by research that identified the association between Indigenous communities that have a strong ‘cultural continuity’ with significantly lower rates of suicide among their young people, in comparison to communities under cultural stress. In broad terms, cultural continuity refers to self-determination and cultural maintenance. It is thought that young people from a strong cultural background have a sense of their past and their traditions and are able to draw pride and identity from them. By extension, they also conceive of themselves as having a future as bearers of a continuing stream of culture.

Participants in the consultations for the Strategy, drawn from across Indigenous Australian communities, consistently called for community-focused, holistic and integrated approaches to suicide prevention with an emphasis on investment in ‘upstream’ prevention efforts to build community, family and individual resilience, and on restoring social and emotional wellbeing.

There is a high level of need in Aboriginal and Torres Strait Islander communities for a range of culturally appropriate and locally responsive healing, empowerment and leadership programs and strategies. Critical to the success of these responses is a high level of community ownership. Fostering cultural continuity is a vital part of suicide prevention in Indigenous communities. Decreased suicide rates have been found to correlate with the number of indicators of cultural continuity present in a community, including: self-government, land claims, community-controlled services, (including police and fire services, health services, child protection and education), knowledge of Indigenous languages, women in positions of leadership, and facilities dedicated to cultural purposes.

A further critical factor is the presence of culturally competent suicide prevention services in communities. An example of quality indicators for such services can be found in the Operational Guidelines for Aboriginal and Torres Strait Islander Suicide Prevention Services to the Access to Allied Psychological Services (ATAPS) program. According to these guidelines, services should aim to:

- provide culturally safe, non-triggering management, treatment and support to Aboriginal and Torres Strait Islander peoples at high risk of suicide or self-harm at a critical point in their lives and to mitigate the reverberations from suicide in the client’s community
- be staffed by administrators and clinicians that are trained and understand mental health and suicide prevention cultural safety
- establish management protocols that reflect the multiple levels of diversity found in modern Aboriginal and Torres Strait Islander populations, and
- be based on Aboriginal and Torres Strait Islander peoples’ definitions of health, incorporating spirituality, culture, family, connection to the land and wellbeing and grounded in community engagement.

Optimally, such approaches need to be developed and provided in partnership with Aboriginal Community Controlled Health Services. The Commission remains committed to witnessing a decrease in the rate of suicide in Aboriginal and Torres Strait Islander communities, and will continue to keep this as one of our key areas of interest.
What we don’t know

Where we need more evidence and to shine a light

Suicide is often described as being ‘in the shadows’, ‘hidden’, or ‘silent’. The true prevalence of suicide, how to reliably predict it, and how to best prevent it are also largely hidden from our view.

Suicide research focuses on the epidemiological study of prevalence and risk factors. We are lacking qualitative work with those bereaved by suicide, who experience suicidal thoughts, or who have gone through a suicide attempt.\(^\text{298}\) Accessing in a sensitive way this lived experience is a research priority, if we are to better understand what helps and what doesn’t. It is a priority which may be jeopardised by the preoccupation with risk by many research ethics committees.\(^\text{298}\)

Even basic information about rates of suicide is difficult to know accurately, because of differences in reporting standards, difficulty determining intent, delays in Coronial verdicts, and insurance- and stigma-related barriers. Australia is currently attempting to standardise suicide reporting across the country. Without this, we cannot know whether interventions have had any positive effect.

There is no assessment tool or known constellation of risk factors which can reliably predict the likelihood that someone will take their own life.\(^\text{299}\)

In terms of what works for suicide prevention, we are only just starting to scratch the surface. We do not know the impact of our National Suicide Prevention Strategy, for example, on suicide rates. One particular aspect of implementation which we instinctively know would help is continuity of care and follow-up.\(^\text{299}\) This deficit in our current systems has been emphasised in the highest level inquiries and policies.\(^\text{271-273}\) This work recognises the need for collaboration between government departments, levels of government, local service providers from health, education, justice, housing and employment, and service planners and people at risk.

We are far from having an integrated system of prevention backed up by standards, evaluation and monitoring to provide:

- community-level understanding of warning signs
- clear and easy access points for help, and
- a ‘seamless service’ for those at risk of suicide or who have attempted suicide.

Part of the problem is that our suicide prevention policies and strategies currently do not offer any sense of what interventions should be prioritised.\(^\text{298}\) We have a fragmented system made up of isolated programs running in parallel. This approach does not catch people falling through the ‘gaps’ between services or ensure they access help in the first place.

One solution has been proposed by leading Australian suicide researchers, who recommend widespread implementation of the few proven prevention approaches, alongside small-scale piloting and evaluation of innovative approaches.\(^\text{298}\)
It has been estimated that over 2.1 million Australians have seriously considered suicide in their lifetime and over half a million people have acted on these thoughts. 

Each year, about 65,300 people attempt to take their own life. The patterns of inequality we have seen in suicide rates are also reflected in attempts, with the exception that women are more likely to attempt suicide than men.

The biggest risk factor for a completed suicide is a previous attempt. We know from international evidence that for people who sought hospital Emergency Department (ED) treatment following a suicide attempt, one in six attempts is followed by another within the following 12 months, and that up to one in twenty of those people attempting suicide will die by suicide during the next nine years.

Supporting those who have made a suicide attempt is a significant opportunity for preventing later deaths. We are hampered in this effort because we are lacking good follow-up data on what happens to people who self-injure or attempt suicide. As a result we cannot know what services and supports actually work. We repeat our call for better community surveillance and communication about suicide attempts.

Any suicide attempt indicates extreme psychological distress. Although we have some statistics about who attempts suicide, we know very little about peoples’ actual experiences. We have commissioned the Centre for Research Excellence in Suicide Prevention to undertake a 12-month-long research study into the nature of such experience, focusing on what helped and what didn’t help people and their families, before and after an attempt.

We know that projects which seek to provide brief interventions in the Emergency Department accompanied by follow-up and outreach can greatly improve outcomes for this group, but also that at present people presenting at EDs can receive poor treatment and little or no follow-up on discharge.

We know less about how to provide outreach services which can intervene before a person gets to the point of attempting suicide. Continuity of care and post-attempt support is known to significantly decrease the chances of a person later taking their own life. We will aim through our study to ascertain the degree to which services across support sectors play their role in ensuring outreach and continuity.

In the meantime, we are encouraged by action taken by police and ambulance services, especially in Victoria, to record suspected suicides in a standardised way. Near real-time reporting of suspected suicide and suicide attempt data by the ambulance service is currently being trialled, but unfortunately this data was not made available to us. We look forward to learning whether this initiative uncovers new information about the rates and patterns of suicide in our communities.
Preventing suicide in LGBTI communities

What it means for Virginia, Tasmania

As the Lesbian, Gay, Bisexual, Transgender and Intersex (LGBTI) Project Officer for Relationships Australia, Tasmania (RA TAS), my role is to develop and implement the LGBTI Suicide Prevention Community Action Plan.

The LGBTI CAP was developed to guide suicide prevention activities for LGBTI people in Tasmania and is an action under the Tasmanian Suicide Prevention Strategy 2010–2014. It is a fluid document that will be updated regularly as activities are completed and new actions agreed.

State-wide consultations with LGBTI community members formed the development of the LGBTI Community Action Plan and three regionally based working groups were formed.

Through the working group, new partnerships were formed between RA TAS stakeholders and the police, health, justice, children and youth, mental health, non-government organisations, education and local LGBTI organisations.

Six key action areas are highlighted in the LGBTI Community Action Plan including: Challenging discrimination and prejudice; Improving education and training; Better access to services and information; Improving health services; Improving crisis and emergency response; and Reducing isolation.

This project was met with many challenges and barriers. Some of those included: working state-wide with many organisations and community members; the political arena of the LGBTI organisations; communication breakdowns between organisations; the conservative nature of some organisations and suspicions from others of what exactly we were doing. There are, however, many more organisations that are very supportive.

Change is slowly occurring and there is certainly willingness of those currently involved to make changes in their own organisations and in their sectors. Work has now commenced on implementing the recommendations and actions in the Plan. Over the next 12 months we will be closely monitoring and evaluating our progress to ensure that we can measure what has actually occurred and where there may still be gaps moving forward.

Watch Virginia’s video at www.mentalhealthcommission.gov.au
Where the Commission is looking for continuous improvement

The Commission wants to see improvement in four key areas in suicide prevention. These are all related to the need for greater understanding of effective ways to reduce the rate of suicidal behaviour and death from suicide.

First, there must be increased funding for research and implementation efforts in line with the burden of disability, suffering, and potential years of life lost to suicide. A recommendation of the 2010 Senate Inquiry into Suicide in Australia recommended a doubling of national suicide prevention program funding and that future increases on top of this be informed by research. The Commission agrees that where we spend money must be based on mandatory and continuous assessment of outcomes. This would form the basis of cost-effectiveness estimates and policy prioritisation.

A second priority is the development of published standards for prevention activities and joined-up support for those experiencing suicide attempts or bereaved by suicide. Such quality standards exist, for example, in Ireland, which may provide a model for Australia to follow. These should be accompanied by a national monitoring and accountability mechanism, recognising that reducing the suicide rate is the responsibility not just of health services but of whole communities.

Thirdly, we need basic infrastructure development to enable us to better assess – in a timely way – the extent and pattern of the problem, and changes over time. Steps towards this are underway; work has commenced on a Victorian Suicide Register to collate detailed information on all Coroner-determined and suspected suicide deaths since 2000. This follows the Queensland Suicide Register which was established in 1990 as the first of its kind in the Asia-Pacific region. Establishing suicide registers with consistent data throughout Australia would be of considerable value.

Fourthly, in line with our philosophy of a contributing life, the Commission would like to see exploration of what a whole-system suicide prevention and response framework would look like. How can we get agencies which historically work in silos to work together to bridge the gaps fallen into by those vulnerable to suicide? We know so little about how to encourage collaboration to provide person-centred support.

The Commission believes that it is unacceptable that every year, more than 2,200 people lose their lives to suicide. In addition, the hidden suffering represented by the 65,300 people who report a suicide attempt each year is staggering. While we can be shocked at this data, we must not forget that behind each number is a person who feels locked into a hopeless situation.

We have emphasised that suicide is an important public health problem. Given this, it is surprising that there is so little evidence about what works in preventing it. We acknowledge that there are no simple solutions to such a complex issue. However, work must continue to bring suicide rates down and to bring the same level of consciousness to the issue as has been seen for drink driving.