# PREVENTION OF YOUTH SUICIDE IN NEW SOUTH WALES

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Ms Melanie Gibbons, MP
Chair, Committee on Children and Young People
Parliament of New South Wales
Sydney NSW 2000

Via: childrenyoungpeople@parliament.nsw.gov.au

Dear Ms Gibbons,

Thank you for the opportunity to provide input into the inquiry being undertaken into the Prevention of Youth Suicide in New South Wales.

*beyondblue* is a national, independent and bipartisan not-for-profit organisation working to promote good mental health, prevent suicide and improve the lives of individuals, families and communities affected by anxiety, depression and suicide. *beyondblue* receives funding from all Australian governments, including the New South Wales Government.

Suicide prevention is a non-negotiable priority for *beyondblue*. Earlier this year, *beyondblue* released an Information Paper and a Position Statement on suicide prevention (see <u>Attachments A and B</u>). The Information Paper provides a snap shot of the relevant evidence base that informs our work and includes an overview of our key strategies as they relate to suicide prevention. The Position Statement outlines what *beyondblue* believes are the most important actions to effectively prevent suicide. It is recommended that the inquiry consider *beyondblue's* recommendations and actions included within the Information Paper and Position Statement.

*beyondblue* is currently developing a five-year Strategic Plan for suicide prevention, which will inform future investments, and build on existing initiatives. *beyondblue's* major investments in suicide prevention include:

- **The Way Back Support Service**, an innovative, non-clinical model for care following a suicide attempt. It is well recognised that one of the greatest risk factors of dying by suicide is a previous suicide attempt, and the risk is particularly high in the first three months. *beyondblue* has developed and trialled The Way Back Service in three locations across Australia, and it is now operating, or soon to be operating, in seven regions, including the Hunter region, Murrumbidgee/Riverina region and North Coast region of New South Wales. The model of care

has been designed for people aged 16 years and over, however, there have been occasions where younger individuals have been referred to the service.

- **The *beyondblue* National Education Program.** In June this year, after a competitive tender process, it was announced that *beyondblue* had been awarded funding to deliver the Mental Health in Education Program. Over the next two years, *beyondblue* will design, implement and evaluate a new, evidence-based, end-to-end mental health program which builds on the strengths of the existing KidsMatter and MindMatters initiatives. *beyondblue* will be the lead service provider, working with Early Childhood Australia and headspace as implementation partners. This program aims to implement an approach to evidence-based mental health promotion, prevention and early intervention and to improve mental health and suicide prevention education in pre-service training for teachers and early childhood staff. A core component of this program will be delivery of suicide postvention services to respond to, and assist, secondary schools in supporting students in the event of a suicide of a student.

- **The BeyondNow safety planning app.** In recognition that suicide risk fluctuates with time and problem solving capability can diminish in a crisis, *beyondblue* developed a safety planning app. BeyondNow is a *beyondblue* application that individuals can download, or access via a website, to create their own suicide safety plan – a personalised risk management approach that can be shared with a health professional or trusted friend. In the two years since its release, there has been nearly 30,000 downloads of the app nationally, 80,000 website views and almost 10,000 suicide safety plans have been created. *beyondblue* continues to promote this intervention and is collaborating with LGBTI and Aboriginal and Torres Strait Islander services and stakeholders to embed the app in services working with at-risk populations.

- **Suicide prevention research.** Research commissioned by *beyondblue* found that people who are experiencing suicidality are not likely to be understood or supported by their friends, family and colleagues in ways that are helpful, despite a willingness by the community to play a role. Findings suggest people lack confidence and skills as to how to approach somebody who might be at risk. Prevailing stigma, a lack of empathy, and significant discrimination within the health system were identified by respondents as reasons for not seeking help. *beyondblue* intends to imbed this research in our five-year suicide prevention strategy, to be finalised later this year.

- **Online forums.** *beyondblue's* Online Forums provide a platform for discussions and peer support about depression, anxiety, suicide and other issues in an anonymous supported environment. The forums are carefully moderated; a person posting content deemed to be at immediate risk of harming themselves or others is contacted by the *beyondblue* Support Service. Each month, there are around 90,000 visits to the forums, with around a third of all visitors from New South Wales. Data from the forums indicates that a quarter (26%) of users identified using the forums because they felt suicidal but this proportion was higher among some user groups – rising to 34% among young people (18-24 years); 40% among people who identify as LGBTI; and 34% of people who were unemployed.

Thank you again for the opportunity to contribute to the Committee's deliberations. If you have any questions, please don't hesitate to get in touch with ▮▮▮▮▮▮▮▮▮▮▮▮▮▮▮

Yours sincerely

**Susan Anderson**
Acting CEO, *beyondblue*

# *beyondblue* Information Paper: Suicide Prevention

This Information Paper has been developed to provide an in-depth understanding of suicide prevention. It provides an overview of suicide, effective suicide prevention strategies and *beyondblue*'s approach to preventing suicide. It also outlines the national and state/territory-based policy frameworks that underpin suicide prevention initiatives in Australia, and includes recommendations to prevent suicide and suicidal behaviour. This Information Paper may be used as a reference document to inform the development and implementation of suicide prevention strategies, and communications relating to suicide.

## Contents

# Introduction

In a typical year, about 3,000 people in Australia die by suicide. This is more than **eight people every day**. Tens of thousands more people attempt suicide each year. For every suicide, and suicide attempt, there are tragic ripple effects for friends, families, colleagues and the broader community.

*beyondblue* believes that suicide is largely preventable, and everyone can play a role in preventing suicidal behaviour, whether by being more open about the issue to raise awareness and fight stigma, by looking out for and providing support to vulnerable individuals or those bereaved by suicide, or through more formal measures.

To be effective, action needs to be based on accurate data and contemporary evidence about what works to prevent suicide. Suicide has been the subject of extensive social, psychological and medical research over many decades. There is a wealth of epidemiological data documenting associations and trends in suicide and suicidal behaviour and considerable evidence on 'what works' to prevent suicide. Overall, this includes a mix of universal strategies, which improve health and reduce suicide risk of the whole population; selective strategies, which target vulnerable groups within a population; and indicated strategies, which target specific vulnerable individuals within a population. However, there are also still gaps in knowledge as well as poor uptake of proven approaches.

Australia's current approach to suicide prevention has been described as being piecemeal, uncoordinated, and under-resourced. This has contributed to a situation in which the suicide rate has not changed significantly over the past 10 years. It is therefore time to rethink our approach to suicide prevention. We need a new approach that ensures the full and effective implementation of existing evidence-based approaches coupled with continued research into new and better interventions, through a nationally-led and regionally-delivered suicide prevention framework. We need leadership, commitment and action by individuals, family members, health professionals, educators, employers, community leaders, the media and all levels of government.

*beyondblue* is committed to playing its role by generating a national conversation about suicide and advocating for effective reforms, as well as by continuing to implement our projects, programs and services directed to suicide prevention, and trialling new, innovative approaches to reduce suicidal behaviour. In doing so, *beyondblue* will ensure its initiatives are underpinned and informed by the experiences of people affected by suicide and we will advocate for, and champion the needs of people affected by suicide. We will partner with others working to prevent suicide and we will also continue to implement broader strategies which focus on improving the mental health of the whole population and reducing the stigma and discrimination associated with depression, anxiety and suicide, through school, workplace, community and online programs.

# Suicide – an overview

Suicide is the deliberate act of taking one's life and it is mostly preventable. Suicide can be considered as part of a continuum of suicidality ranging from ideation, planning, and attempts, to death by suicide.

## The prevalence of suicidality

There is a lack of reliable and valid data across the continuum of suicidality, which makes it difficult to fully quantify the extent of this issue. Suicide Prevention Australia (2015) has compiled information from the 2007 National Survey of Mental Health and Wellbeing and the Australian Bureau of Statistics suicide data (2016), to indicate the prevalence of suicidal behaviour – including suicidal ideation, suicide planning, suicide attempts, and suicide deaths – as described in Figure 1 and Figure 2. This data shows that **females are far more likely to attempt suicide than males, while males are more likely to die by suicide**. Overall, the proportion of women experiencing some form of suicidality (ideation, planning, and/or attempts) is nearly 1 per cent higher than their male counterparts.[1]

Figure 1: Australian 12-month prevalence of suicidality by gender (2007, 2016)[2,3]

| | Women % | Women no. | Men % | Men no. | All persons % | All persons no. |
|---|---|---|---|---|---|---|
| **Suicidal ideation** | 2.7 | 221,300 | 1.9 | 146,700 | 2.3 | 370,000 |
| **Suicide planning** | 0.7 | 57,500 | 0.4 | 33,500 | 0.6 | 91,000 |
| **Suicide attempts** | 0.5 | 42,700 | 0.3 | 22,600 | 0.4 | 65,000 |
| **Any suicidality** | 2.8 | n/a | 1.9 | n/a | 2.4 | 380,000 |
| **Suicides** | 24 | 735 | 76 | 2,292 | 100 | 3,027 |

N/A: reflects data that is not easily derived from the ABS spreadsheet

Figure 2: Australian 12-month prevalence of suicidality by gender (2007, 2016)[4,5]
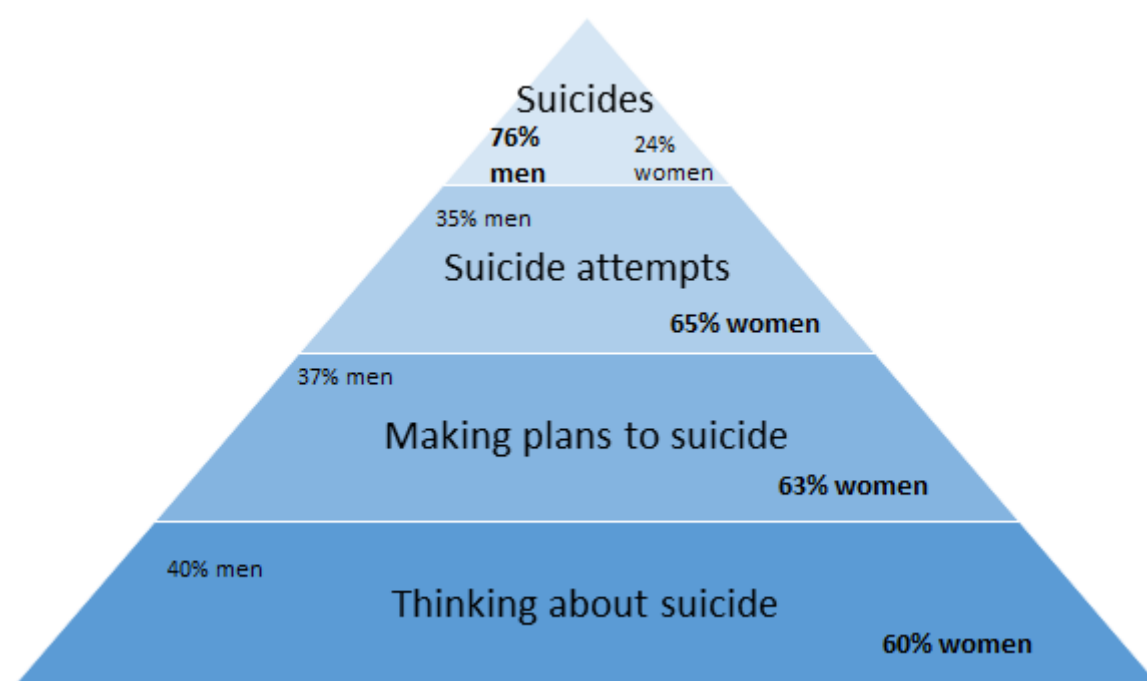
# The suicide rate

In a typical year, about 3,000 people in Australia die by suicide. This is more than **eight people every day**[6] – almost double the national road toll. Tragically, most people who die by suicide are in the prime of their life. Australia's official suicide rate has not changed significantly over the past 10 years, however it has been slightly higher in recent years than it was at the start of the decade (Australia's suicide rate was 10.5 in 2004, and 12.6 in 2015).[7] It is unclear whether this trend is because more people are taking their own life or because data has become more reliable.

Suicide itself accounts for a relatively small proportion of all deaths in Australia (1.9 per cent);[8] however, it accounts for a significantly greater proportion of deaths within certain population groups. **Population groups that have higher suicide rates than others** include:

- **Men** – Men are at least three times more likely to die by suicide than women.[9]
- **Aboriginal and Torres Strait Islander people** – The suicide rate is twice as high for Aboriginal and Torres Strait Islander people than non-Indigenous Australians.[10]
- People with a **mental health condition** or substance misuse – There is a strong association between mental health conditions and suicidal behaviour (For more information see *'The links between mental health conditions and suicide'* below).[11]
- People with a **previous history of attempted suicide**[12] – The occurrence of any level of suicidality, but in particular suicide attempts, is a risk factor for suicide.[13,14,15] A prior suicide attempt is the single most important risk factor for suicide in the general population.[16] The latest data from 2007 indicates that at least 65,000 people attempted suicide in Australia in the previous year.[17] Based on Australia's current population, this would equate to around 75,000 suicide attempts each year. International research suggests that 15 - 25 per cent of those who have attempted suicide re-attempt, and 5 - 10 per cent die by suicide.[18,19,20] The highest risk period to die by suicide is in the first three months following an attempt.[21]
- People living in **rural and remote communities** – Remoteness is a major risk factor contributing to suicide and the likelihood that someone will die by suicide appears to increase the further away they live from a city.[22] The geographic and social isolation, unemployment and economic issues, the misuse of alcohol and other drugs,[23] greater access to lethal means such as firearms and pesticides, together with a relative lack of accessible mental health services in these communities, may contribute to this high rate of suicide.[24]
- **Lesbian, gay, bisexual, trans and intersex** (LGBTI) people – The life experiences which LGBTI people face including exclusion, discrimination, and verbal and physical abuse place LGBTI people at a higher risk for poorer mental health than heterosexual people. A number of studies have found LGBTI people experience increased risk of developing depression and anxiety, substance use disorders or self-harm and thoughts of suicide, and this is strongly related to homophobic and transphobic abuse and discrimination.[25]
- People from **culturally and linguistically diverse** backgrounds – There is great diversity among immigrant suicide rates depending on their countries of birth. By and large suicide rates of migrants appear to become higher than their country of origin the longer they have been in Australia. However, the rates are still mostly lower than for people born in Australia.[26,27,28] Structural barriers in accessing culturally appropriate health care may contribute to these rates, as well as lack of social support, unemployment and low English language proficiency. Cultural beliefs and values play a strong role in suicidal behaviour and prevention efforts.
- People **bereaved by suicide** – Individuals, particularly children that lose a loved one to suicide are at a heightened risk of suicide themselves.
- People in **certain occupations** – Some people exposed to high job stress environments can be at a higher risk of suicide. Some examples include first responders (i.e. police and emergency services), doctors and other health professionals (i.e. especially those who work in an emergency department), and returned service personnel.

More information on the prevalence of suicide in different population sub-groups is available on the [MindFrame](#) website. A brief snapshot of Australian suicide statistics, including information on the limitations of suicide data, is at Appendix B.

## What age groups are more likely to die by suicide?

The number of deaths by suicide varies across the life course and its impact can be understood in terms of either: numbers of suicides, rates of suicide within age groups, or as a percentage of total deaths within age groups.

- The highest **number of deaths** by suicide occurs in the middle years – that is, **between 25 - 54 years**.[29]

Figure 3: Number of deaths by 5-year age group by gender[30]
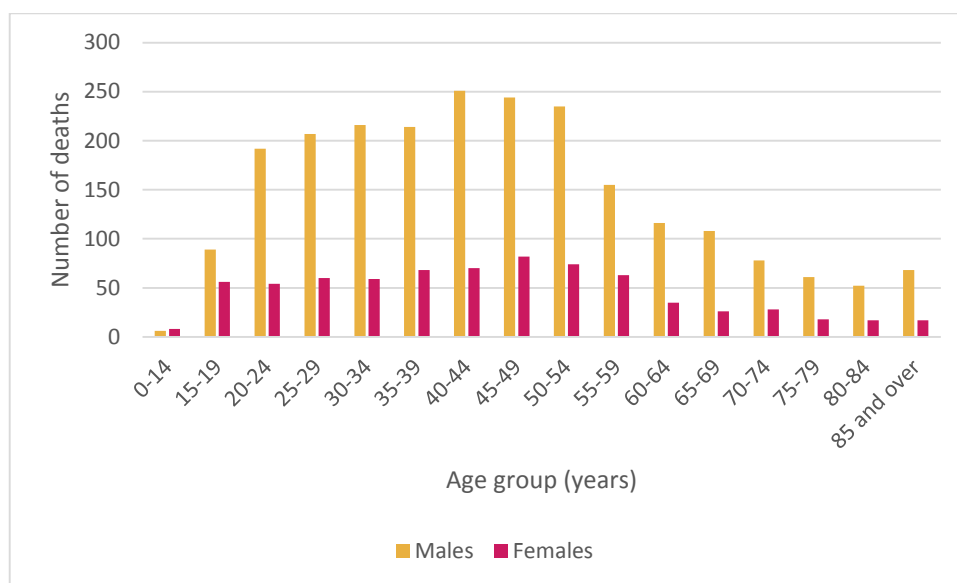


- The highest **rate of suicide** (that is, the number of suicide deaths per 100,000 people in that age band) is among **older males aged 85 years and older.**[31] This reflects a relatively small number of people within this age band.

Figure 4: Suicide rate per 100,000 by 5-year age group by gender[32]
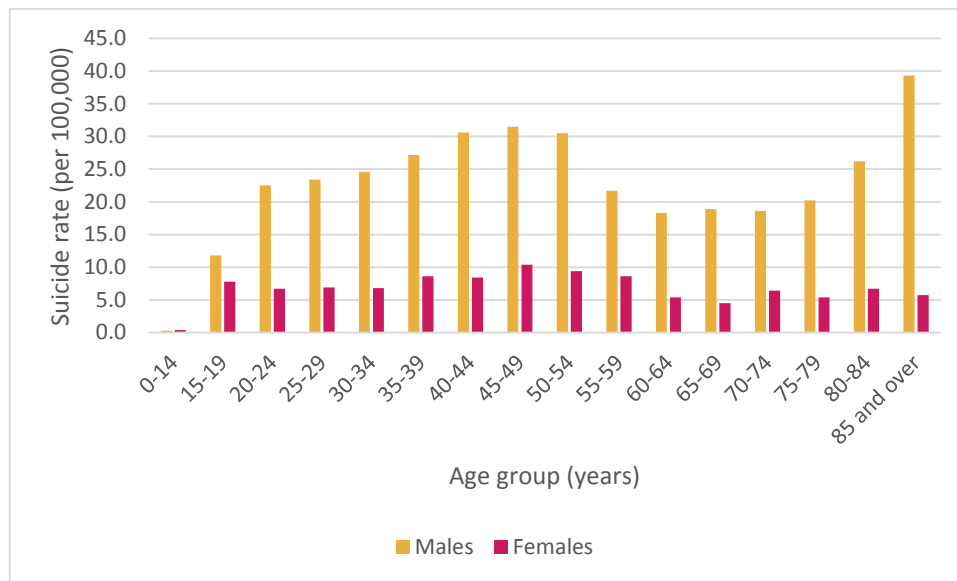


- The highest **proportion of suicide deaths** (that is, the percentage of deaths from all causes which were due to suicide) **is among younger males** – see Figure 5. In 2013, 34.8 per cent of all male deaths aged 15 - 19 were due to suicide; 31 per cent for males aged 20 - 24; and 27 per cent for males aged 25 - 29 years.[33] This reflects the low likelihood of dying by other means during these years.

Figure 5: Suicide as proportion of total deaths within 5-year age groups by gender[34]
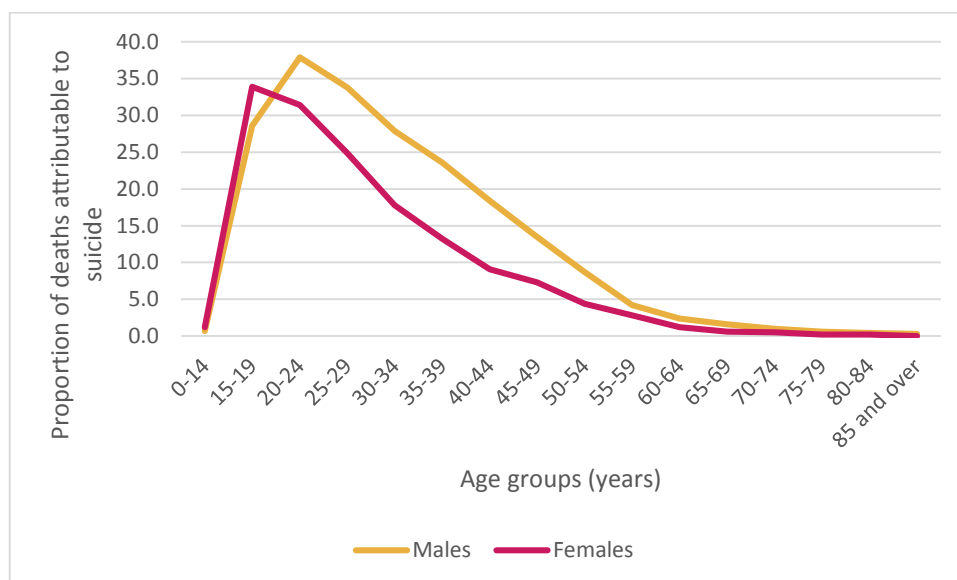


**Given these statistics, it is important that suicide prevention policies and interventions focus on both preventing suicide attempts and suicide deaths across the lifespan.**

# Why do people attempt and die by suicide?

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*"It is critical that there is greater understanding that most often suicide is about ending the pain, not about wanting to leave the world." BlueVoices member*

*"He used to talk about suicide and how he wanted his mental pain to stop and this was his only way out. I feel I have failed my son, my pain is enormous and I miss him so much." Bereaved mother*

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Suicide is ultimately about **overwhelming psychological distress**. People who have survived a suicide attempt report that, rather than wanting to die, they wanted their unbearable pain to end.[35] By and large, suicide occurs when the pain that a person is experiencing is greater than the coping strategies they have. If people are supported to find ways to reduce their pain, to cope with their distress, and to find meaning and purpose in their life, they can exercise other choices and suicide may be prevented.[36]

It is well understood that there is not one single cause of suicide – **it is a complex behaviour with multiple contributing factors, including biological, psychological, social, cultural, spiritual, environmental and economic factors**. There are clear links between suicide and mental health conditions, such as depression; however, **most people with a mental health condition are not suicidal and not all people who take their life have a mental health condition**.[37]

A simplified approach to considering the causes of suicide is within a **'risk and protective factors'** model. Risk factors are those things that may increase the chances of someone dying by suicide, while protective factors are those things that may decrease the likelihood of suicide. The risk and protective factors that contribute to suicide are outlined in Figure 6. Many of these risk and protective factors influence general health and wellbeing. While these risk and protective factors have been found to be important at an aggregate population level, each person's situation is unique and needs to be explored and understood. As such, a focus on risk and protective factors at the population level needs to be complemented by a tailored clinical and psychosocial assessment at the individual level.

Figure 6: Risk and protective factors for suicide[38]

| Risk factors | Protective factors |
|---|---|
| **Individual** | **Individual** |
| Mental health condition | Mental health and wellbeing |
| Chronic pain or illness | Good physical health |
| Immobility or loss of independence | Physical ability to move about freely |
| Alcohol and other drug problems | No alcohol or other drug problems |
| Low self-esteem | Positive self-esteem |
| Little sense of control over life circumstances | Sense of control of life's circumstances |
| Lack of meaning and purpose in life | Sense of meaning and purpose in life |
| Poor coping and problem solving skills | Good coping and problem solving skills |
| Poor emotion regulation/distress tolerance | Positive outlook and attitude to life |
| Hopelessness – feeling trapped | Absence of shame and guilt |
| Shame and guilt | |
| Impulsivity | |
| **Social** | **Social** |
| Abuse, violence, trauma | Physical and emotional security |
| Family dispute, conflict and dysfunction | Family harmony and connectedness |
| Separation and loss | Supportive and caring parents/family |
| Peer rejection | Supportive and prosocial peer relationships |
| Social isolation | Sense of social and community connection |

| | |
|---|---|
| Imprisonment or threat of incarceration | Sense of self-determination and self-agency |
| Poor communication skills | Good communication skills |
| Family history of suicide | |
| Absence of connectedness | |
| **Contextual** | **Contextual** |
| Neighbourhood violence and crime | Safe and secure living environment |
| Poverty and debt | Financial security |
| Unemployment, economic insecurity | Employment |
| Homelessness | Safe and affordable housing |
| Lack of school connectedness and academic failure | Positive educational experience |
| Racism and social, cultural, religious discrimination | Fair and tolerant community |
| Exposure to environmental stressors | Little exposure to environmental pressure |
| Lack of support services | Access to social supports and caring services |

Aboriginal and Torres Strait Islander people have higher rates of suicide than non-Indigenous Australians. Some of the risk factors that contribute to poor mental health conditions among Aboriginal and Torres Strait Islander people are similar to those shared with non-Indigenous people. However, many risk factors are unique to Aboriginal and Torres Strait Islander people or occur far more commonly in the lives of Aboriginal and Torres Strait Islander people.[39] Most of these risk factors relate to the elements that make up the broader concept of social and emotional wellbeing. They reflect the socioeconomic and sociocultural status of the Aboriginal and Torres Strait Islander community in Australia, as well as the day-to-day experiences of individuals from these communities. Key factors include:

- the impact of colonisation and intergenerational trauma caused by previous government policy (e.g. Stolen Generations)
- loss of culture and identity
- unemployment and other forms of social exclusion and inequity leading to alienation and a lack of a sense of purpose in life
- discrimination and racism
- lack of recognised role models and mentors outside the context of sport
- living in overcrowded, substandard or insecure housing
- persistent cycle of grief and 'bereavement overload' due to high number of deaths in communities
- substance misuse among some people (drug and alcohol)[1]
- experience of neglect, abuse or trauma within the family
- exposure to interpersonal conflicts and family violence or family breakdown
- animosity and jealousy manifest in factionalism
- sexual assault and abuse
- sense of hopelessness and feeling trapped.[40,41,42,43,44,45]

Another way to understand suicidal behaviour and suicide is from an individual, psychological perspective. Research shows that the feeling of hopelessness is a major risk factor for the onset of suicidal behaviour. Hopelessness is an important vulnerability and reflects negative feelings about the future and helplessness to improve or change things.[46] The link to suicide risk has been demonstrated among both people with a history of a mental health condition and those without.[47]

The interpersonal theory of suicide describes how high levels of perceived burdensomeness (i.e. feeling a burden to others) coupled with low levels of belongingness (i.e. feeling alienated or that you don't belong) and feeling hopeless that these states will not change, can lead an individual to consider suicide. Suicide ideation alone is not sufficient to cause an attempt, but if an individual then acquires capability to attempt

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[1] Compared to non-Indigenous people, evidence suggests Aboriginal people are less likely to consume alcohol, but those who drink are more likely to do so at harmful levels.

suicide, the risk of an attempt is increased.[48] In this context, capability for suicide pertains to a reduced fear of death and increased tolerance for physical pain. This theory is illustrated in Figure 7.

Figure 7: Interpersonal theory of suicide
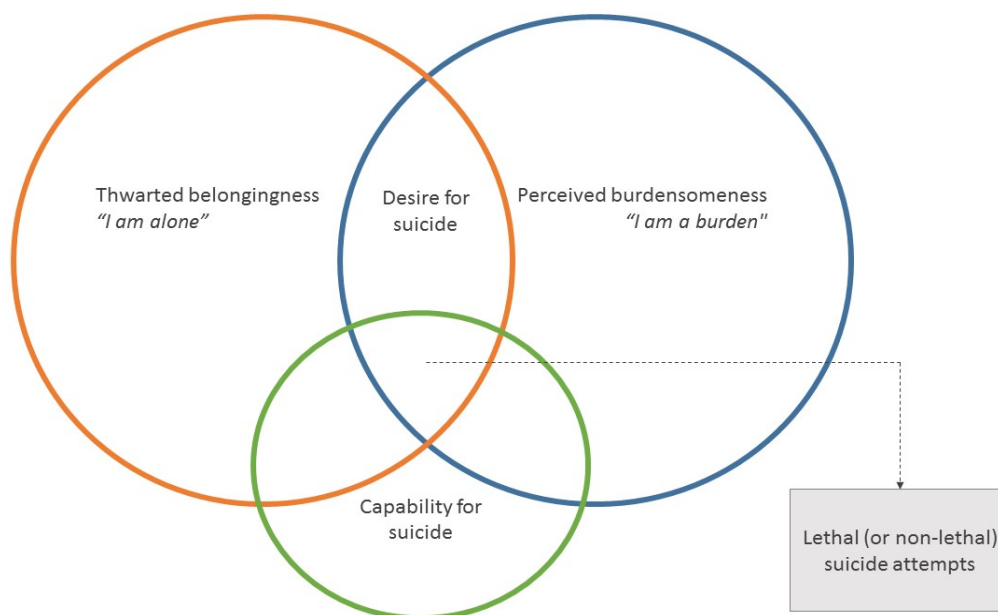


The integrated motivational-volitional model is another example which conceptualises suicide as a behaviour that develops through motivational and volitional phases. The first phase outlines factors involved in the development of suicidal ideation and intent. The other phase describes factors that determine whether an individual attempts suicide. This model is different to the last in that it frames defeat (i.e. feeling defeated after triggering circumstances) and entrapment (i.e. unable to escape from stressful, humiliating, or defeating circumstances) as feelings of greatest importance.[49]

Figure 8: Motivational-volitional model
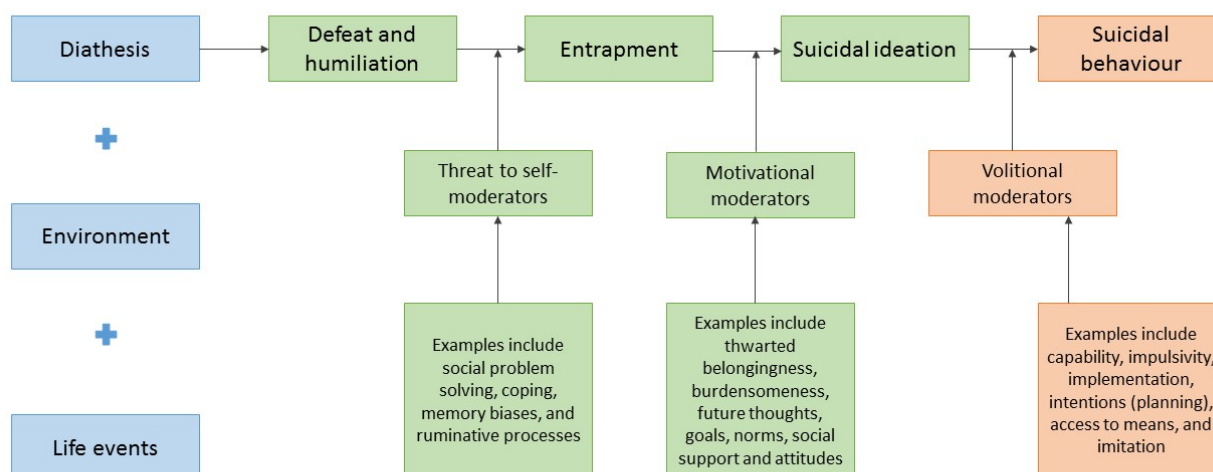


Taken together these psychological theories and models suggest key targets for intervention at an individual level include: de-escalation and resolution of psychological distress through practical support and psychological therapy, social supports, and hope.

# The links between mental health conditions and suicide

**People with a mental health condition are more likely to experience serious suicidal ideation (that is, thoughts about suicide) than people not experiencing a mental health condition** (8.3 per cent compared with 0.8 per cent).[50] The association between mental health conditions and suicidality is strongest for affective disorders (sometimes referred to as mood disorders – see Figure 9). The likelihood of suicidality increases significantly if a person experiences multiple mental health conditions – for example, suicidality in people experiencing anxiety, an affective disorder, and a substance use disorder is almost 50 times higher than among those without a mental health condition (39.2 per cent compared to 0.8 per cent).

Some research suggests that mental health conditions may be present in 90 per cent of suicides, with more than 80 per cent untreated at the time of death.[51] Other researchers question the validity and reliability of this data, as it is underpinned by the psychological autopsy methodology.[52] This methodology is flawed, as it diagnoses a mental health condition by interviewing relatives and friends, sometimes years after the suicide. This is not a valid or reliable way to diagnose a mental health condition.

Figure 9: Prevalence of 12-month suicidality by 12-month mental disorder class[53]

| Mental health condition | Suicidal ideation (%) | Suicide plan (%) | Suicide attempt (%) |
|---|---|---|---|
| No condition | 0.8 | 0.2 | np |
| Affective disorders | 16.8 | 2.4 | 2.1 |
| Anxiety disorders | 8.9 | 2.4 | 2.1 |
| Substance use disorders | 10.8 | 3.5 | 3.1 |
| Any mental disorder | 8.3 | 2.2 | np |

Note: Totals are lower than sum of disorders as people may have had more than one class of mental disorder
np: Not available for publication

Among people with a mental health condition, the risk of suicide is significantly higher where the condition is unrecognised and untreated as well as when treatment is being started or adjusted, during relapse, and after discharge from hospital, emphasising the need for stronger supports during these times of transition.[54,55]

The evidence suggests there are also strong links between alcohol and other drug use disorders and suicide risk.[56,57] People with a diagnosis of substance use disorder are almost six times more likely to report a lifetime suicide attempt than those without a substance use disorder.[58] The link between depression and suicidal behaviour in people who also have a substance use disorder may be particularly important given the high co-morbidity.[59]

It is salient to note that adversity during childhood, such as physical or sexual abuse, particularly when coupled with a lack of off-setting protective factors, is often a common contributing factor to both mental health conditions and substance misuse, as well as being independently associated with suicidal behaviours.[60 61 62 63]

Ultimately however, while there is a strong association between mental health conditions and suicide, it is important to note that **most people who experience mental health conditions are not suicidal and not all people who take their life have an underlying mental health condition**.[64] Interventions therefore need to be holistic and tackle the specific factors that are contributing to an individual's suicidality.

## The link between self-harm and suicide

Self-harm or self-injury refers to people deliberately hurting their bodies.[65] A body of evidence suggests many people who self-harm do not intend or attempt to die; rather it is often used as a coping mechanism, to continue living.[66] The action of self-harm is a way to alleviate emotional pain or distress, or overwhelming negative feelings, thoughts or memories. It could also be a means of self-punishment, to end experiences of dissociation or numbness, or as a way for individuals to communicate to others how low they are feeling.[67] Ultimately, it is a way to change how someone feels by replacing emotional pain or pressure with physical pain.[68]

Self-harm is more common among young people aged 11 to 25 years.[69] The most common type of self-harm among young people is cutting but there are many other types of self-harm including burning, punching the body, picking skin or sores, and deliberately overdosing (self-poisoning).[70,71] For some, self-harm can become a habit as they search for relief from distress. The problem is that this relief is only temporary, and the circumstances usually remain.[72]

While for many people self-harm is a coping mechanism, rather than a suicide attempt,[73] there is a risk that a person may accidently hurt themselves more than they planned. People who repeatedly self-harm may also begin to feel as though they cannot stop, and this may lead to feeling trapped, hopeless and suicidal. Furthermore, people who self-harm are also more likely than the general population to feel suicidal and to attempt suicide.[74]

## The impact of suicide

Each suicide and suicide attempt has significant **personal and social effects**.[75] The effects are immediate and far-reaching – they include feelings of loss and grief, confusion, anger, blame, guilt, shame, distress, frustration, and increased personal risk of suicide.[76,77] People who have survived a suicide attempt may be subjected to misunderstanding and criticism. The stigma associated with suicide can lead to social isolation that further heightens the psychological distress that contributed to the suicidal behaviour. For every suicide, and suicide attempt, there are tragic ripple effects for friends, family, colleagues, and the broader community.[78] Estimates suggest that each **suicide directly impacts on as many as 200 people to different degrees – for 25 people it causes a major disruption to their life and for 11 it has a devastating impact.** Those impacted include family and friends, neighbours, work colleagues, classmates, teammates, clinicians, first responders, coronial staff, volunteers of bereavement support services and others.[79]

*"Because of my job for 20 years, I've seen a lot of trauma, but I have never experienced anything more traumatic than the time my daughter tried to take her own life."*
*Bereaved parent*

*"I feel like I have not been entitled to deal with it openly or socially. It is like my relative died and was buried in unsanctified ground outside the churchyard." Bereaved son*

*"I guess what I'm after is to understand. Not why he did it as I don't think any of us could do that. I want to understand why such a beautiful man has left such a dark place in me. I want to understand how I can make me right." Bereaved friend*

The economic costs of suicide are also considerable and include direct and indirect costs. Direct costs relate to coronial inquiries, police and ambulance services, hospital and medical, and counselling and support provided to friends and family. Indirect costs include the lost economic contribution of an individual who has died earlier in life than expected.[80] The total economic cost of deaths by suicide is estimated to be $1.7 billion per year (calculated in 2010).[81] This estimate includes only deaths by suicide and does not include

costs related to suicide attempts and suicide ideation; other estimates suggest that the **cost is close to ten times that amount ($17.5 billion per year**) when other suicidal behaviours are also included.[82]

Suicide attempts result in significant social and economic burden for communities, due to the use of health services, the psychological and social impact of the suicidal behaviour on the individual and their family/friends/colleagues, and occasionally long-term disability associated with the injury.[83] More importantly, a suicide attempt is the single most important predictor of death by suicide in the general population.[84] Increased accuracy in the recording and reporting of non-fatal suicidal behaviour is essential for improving suicide prevention interventions, resources and policies.[85]

# Effective suicide prevention interventions

The suicide prevention literature is extensive and a number of systematic reviews and meta-analyses have been undertaken to document the current state of knowledge. Evidence-based interventions for suicide prevention include: [86]

- **Universal strategies** – designed to reach an entire population to improve health and reduce suicide risk (e.g. media reporting guidelines, schools, workplaces, campaigns)
- **Selective strategies** – target vulnerable groups within a population based on characteristics such as age, sex, occupational status or family history (e.g. programs for defence force personnel, programs for people with a mental health condition, programs for Aboriginal and Torres Strait Islander people)
- **Indicated strategies** – target specific vulnerable individuals within the population (e.g. those who have made a suicide attempt).

**The World Health Organisation (2014) has developed a summary of effective suicide prevention interventions, which should be included in a comprehensive suicide prevention strategy.**[87] These include:

- **Oversight and coordination** – Provide government leadership and establish institutions or agencies to promote and coordinate programs, training, services and research in respect of suicidal behaviours.
- **Surveillance** – Increase the reliability, validity and timeliness of national data on suicide, suicide attempts and suicide ideation. Support the establishment of an integrated data collection system which serves to identify vulnerable groups, individuals and situations.
- **Means restriction** – Reduce the availability, accessibility and attractiveness of the means to suicide (e.g. firearms, high places). Reduce toxicity/lethality of available means.
- **Media** – Promote implementation of media guidelines to support responsible reporting of suicide in all media modalities.
- **Awareness** – Establish evidence-informed community suicide prevention awareness campaigns. Increase public and professional access to information about all aspects of preventing suicidal behaviour.
- **Stigma reduction** – Change attitudes and beliefs about suicide through awareness. Promote and normalise the use of mental health services, services for the prevention of substance abuse and suicide and reduce discrimination against people using these services. Implement research and campaigns to provide people with the knowledge, tools and permission to talk openly about suicide, while being careful not to inadvertently normalise this behaviour.
- **Training and education** – Implement mental health and suicide literacy programs for the broader community. Maintain comprehensive, targeted training programmes for identified gatekeepers (e.g. educators, workplace health and safety officers, community leaders, police and emergency services). Improve the competencies of mental health and primary care providers in the recognition and treatment of vulnerable persons and deliver specialised suicide prevention training to general practitioners and other front line health workers.
- **Access to services** – Promote increased access to comprehensive services for those experiencing suicidal thoughts and behaviours, and build understanding of how these services may support them. Remove barriers to care. Strengthen the health and social system response to suicidal behaviours.
- **Treatment** – Improve the quality of clinical, evidence-based care, including cognitive behavioural therapy (CBT), dialectical behavioural therapy (DBT) – particularly for borderline personality disorder–

and other clinical interventions through face-to-face and online treatments. Access to treatment is particularly important for individuals who present to hospital following a suicide attempt. Improve research and evaluation of effective interventions.

- **Crisis intervention** – Ensure that communities have the capacity to respond to crises with appropriate interventions and that individuals in a crisis situation have access to emergency mental health care, including through telephone and/or online support.
- **Continuity of care** – Improve the continuity of care and coordination of services for individuals who leave hospital following a suicide attempt.
- **Postvention** – Provide supportive care and services to family, friends and carers impacted by suicide attempts.

Suicide Prevention Australia (2014)[88] highlights the need to incorporate the **experiences of people who have been affected by suicide in research, policy and practice**. The development, implementation and evaluation of all suicide prevention strategies should therefore be done in partnership with people with a personal experience of suicide. Suicide prevention initiatives for Aboriginal and Torres Strait Islander communities should ideally be led by Aboriginal and Torres Strait Islander people, or at a minimum, Aboriginal and Torres Strait Islander people should provide significant input into the design, delivery and evaluation of any proposed intervention (i.e. co-design). Wherever possible, funded programs and services should be provided through Aboriginal community owned and controlled agencies or in direct partnership with them. Mainstream agencies need to work in collaboration with Aboriginal community controlled health organisations and community based service providers, peak bodies, schools, research institutes and Elders rather than trying to assume ownership themselves.

A **systems approach to suicide prevention** will be trialled in four sites across New South Wales, commencing in 2016, led by the Black Dog Institute.[89] This approach requires involvement of medical, health and community agencies in a local/regional area working at the same time to implement a number of different evidence-based suicide prevention strategies (drawing on those interventions outlined above). This approach is estimated to reduce the suicide rate by at least 20 per cent.[90]

It should be noted that while suicide is an external cause of death, and therefore preventable, there are some people whose experience of life is so painful and distressing that even the most well-meaning society, providing evidence-based services, may not be able to provide alternative solutions for them.

## Identified and emerging research gaps

It is important to draw on what we know doesn't work or where there are still gaps in knowledge. Investment is required to build further capacity in the Australian research sector to ensure that it can maintain pace with the need for a strong evidence base to inform policy and practice.

Research is required across the breadth of epidemiological and basic research, through to real world effectiveness studies. Indeed, research from Australia suggests there is still a gap in knowledge about the impact of different interventions on suicide deaths and attempts.[91] Research challenges in this area include establishing standard definitions for suicide-related terms, strengthening assessment tools for identifying at-risk individuals, and refining treatment and support options for at risk individuals, Better evaluation of programs – particularly population level interventions - also needs to be prioritised to fill this void, especially for the Australian context.

Participatory research methods and design should be employed for suicide research in Aboriginal and Torres Strait Islander communities. This approach can increase the capacity of Aboriginal and Torres Strait Islander researchers, and development of culturally inclusive tools, measures and results that are meaningful to the local community.

Australian researchers should consider aligning their work with the National Suicide Prevention research agenda.

# Effective communication on suicide

It is important that we talk about suicidal behaviours and suicide. When doing so, we must ensure that we **use appropriate, non-stigmatising terminology and that we do not inadvertently normalise or glamorise suicide** as an option for dealing with problems.[92]

Guidance is required to enable members of the community to reach out to people that they are concerned about and 'have the conversation'. While many people worry that asking someone if they are considering suicide may encourage them to do so, research shows this is not the case. Nationally, *beyondblue* has commenced the first stage of an Australian-first research project to understand the knowledge, attitudes and behaviours of the general public in supporting people who might be experiencing suicidal thoughts and ideation. This understanding will inform our public communications and advice to people on how to talk about suicide and respond in these instances.

It is also important to note that certain ways of describing suicide can alienate members of the community or inadvertently contribute to stigma and discrimination among people who have attempted suicide or been bereaved by suicide, further compounding their distress and sense of isolation. Promoting the use of non-stigmatising language is therefore equally important.

The media plays an important role in influencing attitudes and perceptions of suicide. Ideally, suicide reports are presented with care to minimise the pain felt by relatives and friends impacted by suicide, and portrayed in a way that does not suggest suicide will solve personal problems or is glamourous. MindFrame is a national media initiative, established to support responsible, accurate and sensitive representation of mental health conditions and suicide in traditional Australian mass media.[93] They provide the following suggestions:

Figure 10: Suicide terminology

| Issue | Preferred language | Problematic language |
|---|---|---|
| Language that presents suicide as a desirable outcome | 'took their own life', 'ended their own life', 'died by suicide' | 'successful suicide', 'unsuccessful suicide' |
| Phrases that associate suicide with crime or sin | 'died by suicide', 'took their own life' | 'commit suicide', 'committed suicide' |
| Language that glamourizes a suicide attempt | 'made an attempt on his life', 'suicide attempt', 'non-fatal attempt' | 'failed suicide', 'suicide bid' |
| Phrases that sensationalise suicide | 'Higher rates', 'increasing rates', 'concerning rates' | 'suicide epidemic' |
| Gratuitous use of the term 'suicide' out of context | Refrain from using the word 'suicide' out of context | 'suicide mission', 'political suicide', 'suicide pass (in sport)' |

# The role of social media

Social media is still a relatively new phenomenon. Fusing technology with social interaction via the internet, it allows for creation and exchange of user-generated content across traditional media boundaries (i.e. states, countries) that may not follow conventional media language rules (i.e. MindFrame guide). Social media platforms include online forums and chat rooms, video sites (e.g. YouTube), blogs and social networking sites (e.g. Facebook, Twitter), as well as email, text messaging and video chat,[94] with the number of users growing exponentially each year.

While researchers continue to grapple with the potential positive and negative impacts of websites and social media for suicide prevention, it must be acknowledged that this is still an emerging area of understanding. Social media and the internet may have both a positive and negative impact on suicide prevention.

Social media provides a platform to promote prevention, support and resources to many people quickly and easily. It can provide a sense of connection or shared community for those otherwise isolated. Some researchers are exploring the potential for social media monitoring to be used to enable people who appear to be at risk of suicide to be identified, contacted and supported.

On the flipside, new media provides another avenue for bullying, particularly among younger people. Australian statistics on cyberbullying suggests one in five children, aged between 8 and 15 have experienced cyberbullying.[95] Research on cyberbullying and its link to suicide is scant, but it is understood that children who have been victims of bullying are nearly three times as likely to show signs of depression and up to nine times as likely to contemplate or attempt suicide.[96]

More research is needed to understand the extent of social media's positive and negative influences on suicidal behaviour and the extent to which people's privacy can be respected while providing avenues to reach out to people at risk, as well as how we can protect people's freedom of speech while counteracting harmful content that may place people at risk. Research should take a focussed approach for young people and adolescents in particular, as a high user group of social media.

# The policy framework

## National

The **'Australian Government Response to Contributing Lives, Thriving Communities – Review of Mental Health Programmes and Services'** sets out a new direction for suicide prevention in Australia, with further commitments made during the 2016 federal election period:[97]

The Government will move to immediately implement a new National Suicide Prevention Strategy with four critical components:

- national leadership and infrastructure, including evidence based population level activity and crisis support services
- a systematic and planned regional approach to community based suicide prevention, which recognises the take-up of local evidence-based strategies. This approach will be led by Primary Health Networks who will commission regionally appropriate activities, in partnership with Local Hospital Networks and other local organisations
- refocused efforts to prevent Indigenous suicide
- Work with state and territory governments to ensure effective post discharge follow up for people who have self-harmed or attempted suicide, in the context of the Fifth National Mental Health Plan.

In addition, the Government have committed to:

- implement 12 suicide prevention trial sites in partnership with Primary Health Networks.
- invest $12 million over 4 years in a suicide research fund
- invest in a pilot of follow-up text messaging for crisis support and suicide prevention
- exploring workforce issues for mental health nurses in collaboration with Primary Health Networks.

The Government has also committed to measuring progress on reducing suicide, including developing a key performance indicator to measure progress in implementing the principle of active follow up support for people who have attempted suicide.

The Government's new direction in suicide prevention follows the **National Mental Health Commission's review of mental health programmes and services**. This review found that the existing approach to suicide prevention was *"too fragmented, lacks sufficient focus and operates from too small a resource base to achieve a meaningful impact on these [suicide] rates. It is not working effectively and a new approach is needed."* The Commission proposed a regional-based, sustainable, comprehensive, whole-of community approach to suicide prevention, and called for a 50 per cent reduction in suicides and suicide attempts over the next decade. While the Commonwealth Government has not adopted this ambitious goal, it has committed to moving towards a regional, systems-based approach to preventing suicide.

In addition to the National Mental Health Commission's review of mental health programmes and services, a number of other **national inquiries and reports** have raised the profile and public dialogue associated with suicide prevention. These include:

- the Senate Inquiry into Suicide in Australia (2010)
- the House of Representatives Inquiry into Early Intervention Programs aimed at Reducing Youth Suicide (2011)
- the National Children's Commissioner's Intentional self-harm and suicide in children inquiry (2014)
- the National Mental Health Commission's National Report Cards on Mental Health and Suicide Prevention (2012, 2013).

## State/Territory

Each State and Territory also has its own jurisdiction-based suicide prevention strategy. These include:

- *Australian Capital Territory - Managing the Risk of Suicide – A Suicide Prevention Strategy 2009-2014*
- *New South Wales – Proposed Suicide Prevention Framework for NSW*
- Northern Territory - NT Suicide Prevention Strategic Action Plan 2015-2018
- Queensland – Queensland Suicide Prevention Action Plan 2015-2017
- South Australia - Suicide Prevention Strategy 2012-2016
- Tasmania - Suicide Prevention Strategy 2016-2020
- Victoria - Victorian Suicide Prevention Framework 2016-2025; *the Victorian Aboriginal Suicide Prevention and Response Action Plan 2010-2015*
- Western Australia – Suicide Prevention 2020: Together we can save lives

## Cross-jurisdiction collaboration

A system that supports collaboration and sharing of knowledge and insights is vital for success. The most successful model will combine a mix of national and jurisdiction-specific approaches, integrating evidence-based interventions managed locally, combined with selective initiatives supported at a national level (e.g. helplines, resource development, campaigns).

It is also important that suicide prevention is considered as a national effort operating across Commonwealth, State and Territory jurisdictions, and responsibility extending beyond the mental health sector. This recognises that determinants of good mental health are influenced by a range of factors, many of which are outside the health system. A broad approach provides the best opportunity to impact on the stigma and discrimination that people affected by suicide experience in their life – at home, at work, at school, and within the community.

# Recommendations to prevent suicide and suicide attempts

A comprehensive, nationally-led and regionally-delivered approach to suicide prevention is required led by government and involving the whole community. Coordination and collaboration is needed to ensure the impact of investments are maximised. Key principles of any high-level strategy include:

- **Leadership and long-term funding from the Commonwealth and State and Territory governments.** A short-term funding focus can undermine efforts to secure long-term and effective community participation and change. Long-term funding cycles should be adopted. **Pooling funding from both the Commonwealth Government and States and Territories** is likely to improve the impact of programs, remove fragmentation and duplication, and improve accountability for achieving outcomes.
- **Involving the community through an effective community engagement approach.** Community engagement approaches improve the effectiveness, efficiency, sustainability and uptake of suicide prevention initiatives, and should therefore be adopted. People affected by suicide should inform and actively contribute to suicide prevention priorities and interventions.
- **Having strong governance arrangements,** which include local leadership and control, clear decision-making processes and lines of accountability.
- **A systems approach.** This requires a combined population and individual level approach with involvement of health and non-health agencies in a local/regional area working at the same time to implement a number of different evidence-based suicide prevention strategies.
- **A focus on preventing both suicide attempts and suicide.** The current approach in policies, programs, funding and research has focused on understanding and preventing suicide mortality. While this is

clearly important, non-fatal suicidal behaviour also has a significant impact on individuals, communities and the health system, and also needs to be considered. Action is required across the whole spectrum of suicidality, and not just for people at high or imminent risk.

- **A tailored and intensive approach to reduce suicide in Aboriginal and Torres Strait Islander people**. This should harness the strengths and expertise of Aboriginal and Torres Strait Islander leaders and communities, respond to the social and economic disadvantage that disproportionately affects Aboriginal and Torres Strait Islander communities, and enhance connection to culture and community.
- **A data driven and evidence-based approach.** Strong data and surveillance systems, an emphasis on research, evaluation and continuous improvement and a commitment to turning evidence into action.

# Appendix A – Glossary of terms

| Term | Definition |
| --- | --- |
| Affective disorders | A class of mental health conditions; one of their key features is mood disturbance. Examples of affective disorders include depression, bipolar disorder, seasonal affective disorder (SAD). |
| Anxiety disorders | A class of mental health conditions that involve the experience of intense and debilitating anxiety. Examples of anxiety disorders include panic disorder, social phobia, agoraphobia, generalised anxiety disorder, posttraumatic stress disorder (PTSD) and obsessive compulsive disorder (OCD). |
| Depression | Sometimes called major depressive disorder, major depression, clinical depression, or unipolar depression. It involves low mood and/or loss of interest and pleasure in usual activities, as well as other symptoms. The symptoms are experienced most days and last for at least two weeks. Symptoms of depression interfere with all areas of a person's life, including work and social relationships. Depression can be described as mild, moderate or severe. |
| Gatekeeper | Those individuals in a community who have face-to-face contact with large numbers of community members as part of their usual routine. |
| Gatekeeper training | Training provided to gatekeepers (see above) to identify persons at risk of suicide and refer them to treatment or supporting services as appropriate. |
| Postvention | A strategy or approach that is implemented after a crisis or traumatic event has occurred, namely a suicide or suicide attempt. The strategy may be to support bereaved family and friends, as well as individuals who attempt suicide. |
| Safety Plan | A safety plan is a structured plan – ideally developed with support from a health professional or someone trusted – that an individual can work through when they're experiencing suicidal thoughts, feelings, distress or crisis. |
| Self-harm | Also known as deliberate self-injury, non-suicidal self-injury, intentional self-injury and parasuicide. Common methods include cutting and burning. |
| Stigma | Marks people as being 'different' from others, in a way that generates distance or disapproval. There are different types of stigma including personal stigma, perceived stigma, self-stigma and structural stigma. |

| | |
|---|---|
| | If stigma results in someone treating another in a negative way, this is considered discrimination. |
| Substance use disorders | These occur when the recurrent use of alcohol and/or other drugs causes clinically and functionally significant impairment, such as health problems, disability, and failure to meet major responsibilities at work, school, or home. |
| Suicide | The deliberate act of taking one's life. Suicide can be considered as part of a continuum of suicidality ranging from ideation, planning, and attempts, to death by suicide. |
| Suicide attempt | A potentially self-injurious behaviour with a nonfatal outcome, for which there is evidence that the person intended to kill themselves. |
| Suicidal crisis | A situation in which a person is attempting to kill themselves or is seriously contemplating or planning to do so. |
| Suicidal ideation | Defined as serious thoughts about engaging in suicide-related behaviour or taking one's own life. |
| Suicide rate | The proportion of deaths resulting from suicide, compared to the total number of deaths over a given time frame. |

# Appendix B – Australian suicide statistics

## Brief snapshot of suicide data

The Australian Bureau of Statistics (ABS) updates suicide statistics in March each year. Mindframe provides up-to-date statistics, which should be referred to as needed.  A summary of the latest suicide data (as at March 2016), sourced from Mindframe, is listed below. To check if more recent data is available, visit: http://www.mindframe-media.info/for-media/reporting-suicide/facts-and-stats

- Suicide is a prominent public policy issue. Over a five year period from 2011 to 2015, the average number of suicide deaths per year was 2,687.
- In 2015, 2,292 males (19.4 per 100,000) and 735 females (6.2 per 100,000) died by suicide, a total of 3,027 deaths (12.6 per 100,000), which equates to an average of 8.2 deaths by suicide in Australia each day.
- For those of Aboriginal and Torres Strait Islander descent, there were 152 deaths due to suicide (110 male, 42 female). The relative age standardised suicide rate was twice as high in both Aboriginal and Torres Strait Islander males and females as non-Indigenous males and females (1.8 and 2.0 respectively).
- The highest age-specific suicide rate for males in 2015 was observed in the 85+ age group (39.3 per 100,000). This rate was considerably higher than the age-specific suicide rate observed in all other age groups, with the next highest age-specific suicide rate being in the 45-49, 40-44 and 50-54 year age groups (31.5, 30.6 and 30.5 per 100,000 respectively). The lowest age-specific suicide rate for males was in the 0-14 year age group (0.3 per 100,000) and the 15-19 year age group (11.8 per 100,000).
- The highest age-specific suicide rate for females in 2015 was observed in the 45-49 age group (10.4 per 100,000), followed by the 50-54, 35-39 and 55-59 age group (9.4, 8.6 and 8.6 per 100,000 respectively). The lowest age-specific suicide rate for females was observed in the 0-14 age group (0.4 per 100,000) followed by the 65-69 age group (4.5 per 100,000) and the 60-64 and 75-79 age group (both 5.4 per 100,000).
- Suicide rates in Australia peaked in 1963 (17.5 per 100,000), declining to 11.3 per 100,000 in 1984, and climbing back to 14.6 in 1997. Rates have been lower than this since that year. The age-standardised suicide rate for persons in 2015 was 12.7 per 100,000.
- Consistently over the past 10 years, the number of suicide deaths was approximately 3 times higher in males than females. In 2015, approximately 76% of people who died by suicide were males.
- Suicide accounted for 1.9% of death from all causes in 2015. In males 2.8% of all deaths were attributed to suicide, while the rate or females was 0.9%.

## Suicide data limitations and considerations

Mindframe[98] makes the following notes about using and interpreting suicide statistics:

*Reporting on suicide*

- Data on suicides can be reported in different ways, including: the number of people who died by suicide; the age-standardised suicide rate (e.g. seven per 100,000 people, this allows for the comparison of groups with different age structures and sizes); and as a percentage of deaths from all causes which were due to suicide.
- Due to the relatively small numbers of suicides in some states and territories, even one or two deaths can have a significant impact on standardised suicide rates. Thus comparisons across Australia must be done cautiously.

*The reliability and validity of suicide statistics*

- In the past, the reliability of suicide statistics was affected by a number of factors including differences in state-specific reporting methods across Australia, and delays in the post-mortem processing of possible suicides by coroners.
- The ABS has instituted a significant quality assurance process to improve the quality of coding of deaths data. ABS advises that care should be taken in comparing 2013 suicide data with all suicide data from 2006 - 2012, as these data have been subject to a quality improvement review process.
- In order to further improve the accuracy of the data on suicide deaths, the ABS has continued its new approach of revising the preliminary *Causes of Death* data. The ABS currently release the preliminary results each year, which are subject to revision for a following two years to account for any additional deaths attributed to suicide that were undergoing coronial investigations upon the initial release of the preliminary data. Consequently, in the most recent release, data for 2013 had its first yearly revision, with data from 2012 subject to its second and final revision.
- The comparison of international suicide statistics can be very difficult due to differences in procedures for coronial reporting and classifying deaths, definitions, time periods, and the level of undercounting.

# Appendix C - *beyondblue* suicide prevention strategies

Suicide prevention is an integral focus of *beyondblue's* activities and one in which we are becoming increasingly active. There is also a growing recognition among governments across Australia for the need to increase the focus on suicide prevention and to take a more structured approach to this public policy issue.

*beyondblue* integrates a focus on suicide prevention across all of its information, resources and programs, and works in partnership with the suicide prevention sector (e.g. *beyondblue* is a member of the National Coalition for Suicide Prevention, Suicide Prevention Australia and is an industry partner of the Centre for Research Excellence in Suicide Prevention).

*beyondblue's* suicide prevention activities are informed by the evidence on what works to effectively prevent suicide, as described by the World Health Organisation (see *'Effective suicide prevention interventions'*). While it is not possible to deliver programs or activities in all areas, *beyondblue's* work in this space aims to be holistic, multi-level and coordinated, combining both whole of population and individual focussed strategies. They include:

## Media

*beyondblue* adheres to the MindFrame guidelines to ensure that we report and portray suicide and mental health conditions in a sensitive and responsible manner. We initiate widespread media coverage of depression, anxiety and suicide to encourage a community conversation.

## Promoting good mental health

*beyondblue* encourages and assists people in education, employment and community spaces to provide environments that promote good mental health, and minimise the risk of depression, anxiety and suicide. These 'upstream' prevention initiatives aim to increase protective factors associated with good mental health. They include:

- **School-based programs** – *beyondblue's* KidsMatter (www.kidsmatter.edu.au) and MindMatters (www.mindmatters.edu.au) programs adopt 'whole of school' approaches to support student mental health and wellbeing, and strengthen school capacity to support students experiencing mental health difficulties.
- **Workplace-based programs** - Heads Up (www.headsup.org.au) is an Australian-first initiative of *beyondblue* and the Mentally Healthy Workplace Alliance. It supports Australian businesses and workers to create more mentally healthy workplaces. Heads Up includes information and resources on suicide prevention in workplaces. This includes identifying and supporting someone at-risk of suicide, supporting someone who has attempted suicide, and implementing broader suicide prevention strategies such as developing organisational policies and procedures and staff training.
- **Social connectedness initiatives** –*beyondblue,* with support from the Movember Foundation, conducted a **research project on the links between depression, anxiety, suicide and social connectedness**, in particular focusing on older adults and men aged 30 – 65 years. Following this research project, *beyondblue* developed a **'Connections Matter' booklet**, which provides older people with practical and evidence-based suggestions on how to help strengthen and maintain social networks. *beyondblue* is also participating in the international **'Mateship Innovation Challenge'**, which is being run by the Movember Foundation and conducted in Australia, Canada and the United Kingdom. This Challenge will support innovative concepts that demonstrate how men in their middle years can build strong relationships with their peers.

## Awareness

*beyondblue* has developed **national advertising campaigns and resources focusing on depression and anxiety**. A comprehensive research project on current community attitudes and beliefs about suicide will underpin further work in this space. If the evidence supports it, a **suicide prevention awareness campaign** will be developed, implemented and evaluated nationally.

Existing campaigns have been developed to cover a range of conditions (such as depression, anxiety, perinatal depression); life stages (for example, youth, older people); population groups (for example, lesbian, gay, bisexual, trans and intersex people, Aboriginal and Torres Strait Islander people); and settings (for example, rural communities). *beyondblue*'s campaigns are based on extensive quantitative and qualitative research with people with depression and anxiety and their family and friends, and provide insights into personal experiences. Campaign messages are disseminated and promoted via print, television, radio, cinema advertising, outdoor billboards, community events and forums and social media. *beyondblue* has also developed a comprehensive suite of **free information and resources**, including translated materials, which are disseminated to individuals, community groups, health centres, libraries, schools, universities, workplaces and many other settings.

## Stigma reduction

*beyondblue* believes that all stigma and discrimination experienced by people affected by depression, anxiety and suicide is unfair and needs to stop. We support whole-of-community approaches to reduce stigma and discrimination, that includes the sharing of personal stories of depression, anxiety and suicide, and recovery; challenging inaccurate stereotypes about depression, anxiety and suicide; developing a more accurate understanding of what it is like to experience or be affected by depression, anxiety and suicide; and non-discriminating communities, systems and institutions.

*beyondblue* has a range of initiatives to reduce stigma and discrimination. These include:

- ***beyondblue* speakers bureau** – *beyondblue* has a pool of speakers who have a personal experience of depression, anxiety and/or suicide. The speakers share their stories of recovery and encourage others to take action and get the support they need, at public events, community forums and to the media.
- **blueVoices** – blueVoices is *beyondblue*'s reference group of people with personal experiences of depression, anxiety and/or suicide and their family and friends. blueVoices members share their personal experiences and perspectives to inform *beyondblue*'s work – for example, in campaigns, information resources, project reference and advisory groups, and research projects.
- **The STRIDE project** – *beyondblue*, with funding from The Movember Foundation, has commissioned six research partnerships to demonstrate the impact of digital interventions to reduce the stigma of anxiety, depression, and/or suicide in Australian men aged 30 to 64 years.
- **National campaigns and media coverage** – as described under 'media' and 'awareness'
- **Social media** – *beyondblue* utilises its strong social media presence to reduce the stigma of depression and anxiety and support awareness and help seeking to prevent suicide. Social media is used to:
  - Engage audiences and increase reach – through content which encourages people to get to know more about *beyondblue* and its work.
  - Provide support for people experiencing depression or anxiety, or support someone close to them
  - Encourage help seeking – *beyondblue*'s Facebook, Twitter and Instagram provide access to information and links to support, including *beyondblue's* Support Service
  - Enable conversations about depression and anxiety – through *beyondblue*'s online forums, Twitter and Facebook communities, there is a public place for people to share their stories of depression and anxiety and receive advice and support from others, and for *beyondblue* to learn from community reaction and feedback.
- **Conversations project** —— a suite of digital resources has been developed to help people have a conversation about anxiety and depression. These resources will increase the confidence and skills of people to talk about depression and anxiety across a range of settings, including among families and friends, workplaces, and with health professionals.

- ***beyondblue* workplace training programs** – *beyondblue* has a face-to-face training program and a series of online resources to raise awareness of depression and anxiety in the workplace, and provide practical strategies to support individuals and promote mental health. The training programs and resources include personal stories of depression, anxiety and suicide, which aim to increase understanding of these conditions and experiences, and reduce the stigma and discrimination experienced in workplaces.
- **Discrimination and insurance program** – *beyondblue* and Mental Health Australia have been working together for the past ten years to reduce the discrimination experienced by people affected by depression, anxiety and suicide in the insurance industry. While there have been some improvements, such as the development of industry-wide guidelines for insurance sector staff, real change has been slow to happen. *beyondblue* and Mental Health Australia are now building an awareness and advocacy campaign to respond to this discrimination, and are encouraging people to share their stories. Up-to-date information is available at: http://www.beyondblue.org.au/about-us/programs/system-reform-and-access/discrimination-in-insurance

## Training and education

*beyondblue* has developed comprehensive **information for the general public on how to recognise and help a person at risk of suicide**. This includes information on:

- how to tell if someone is at risk of suicide
- common warning signs
- responding to warning signs
- supporting someone you are concerned about

This information and links to other resources and support organisations is available on the *beyondblue* website - www.beyondblue.org.au/the-facts/suicide-prevention A guide specifically to support **parents of young people who may be at-risk of suicide**, which includes video resources, has also been developed, and is available at - www.beyondblue.org.au/resources/family-and-friends/parents-and-guardians/family-guide-to-youth-suicide-prevention

*beyondblue* is also implementing a number of projects targeting **front line staff, including police, ambulance and other emergency services workers**. These include:
- **The *beyondblue* Police and Emergency Services Program** – which aims to improve the mental health of first responders and reduce their risk of suicide. *beyondblue* has developed a good practice model to support police and emergency services organisations promote and protect the mental health of their employees.
- ***beyondblue*'s Professional Education to Aged Care (PEAC) program** – this program aims to raise awareness about depression and anxiety in older people and heighten the skills of staff working in the aged care sector in regards to these conditions. The program is delivered both face-to-face and online, and includes information and skills on identifying and responding to suicide.

## Access to services and treatment

*beyondblue* is improving access to mental health services and treatment through:
- increasing the community's awareness and understanding of mental health conditions and suicidal behaviour – for example, through campaigns and information resources
- improving the community's capacity to recognise and effectively respond to depression, anxiety and suicide – for example, through skill-based training programs in schools and workplaces
- delivering accessible and alternative models of care, which ensure that people get appropriate and timely help.

*beyondblue's* accessible and alternative models of care include:

- **The *beyondblue* Support Service** (1300 22 4636 - www.beyondblue.org.au/getsupport) – this Service provides immediate, short-term, solutions-focused support and referral services via a 24/7 telephone service, web chat service from 3pm to midnight, and an email response service. The Support Service is

not a suicide or crisis line, however suicide-related issues are discussed and users are supported to access services to best meet their needs, including those people who are assessed as being at high-risk of suicide.

- **Online programs**:
  - o *beyondblue's* **websites** enable people to assess their mental health through completing a K-10 anxiety and depression checklist, and linking people into appropriate services if they are at-risk of anxiety or depression.
  - o *beyondblue's* **online forums** provide opportunities to reduce social isolation and facilitate peer-to-peer support (see: www.beyondblue.org.au/connect-with-others/online-forums). There are 68,000 unique monthly visits and over 5,000 monthly posts. The most recent snap shot of users demonstrated that:
    - 67 per cent of users reported feeling less depressed or anxious after accessing the forums
    - 38 per cent claimed they have contacted a health professional as a direct result of using the forums
    - 69 per cent indicated they have made a positive lifestyle change such as more exercise, meditation, connecting more with family and friends, reducing alcohol and drug use or diet changes as a direct result of using the forums.
- **The NewAccess program** – this is a demonstration project that provides a support service to help people with mild-moderate depression and/or anxiety conditions. Trained and clinically supervised coaches operate like personal trainers, providing individual tailor-made low intensity Cognitive Behaviour Therapy strategies and support such as problem solving, goal setting and dealing with worries.

## Crisis intervention

*beyondblue* working in conjunction with Monash University and with support from The Movember Foundation, has developed the **BeyondNow safety planning app –- which allows clinicians and people at-risk of suicide to create a digital safety plan**. The App is designed to prevent suicide by providing people with a specific set of concrete strategies to use, in order to decrease the risk of them acting on their thoughts and harming themselves. It provides an escalation process that encourages people to identify their warning signs and take action early, implementing strategies themselves that help them cope. If these strategies are not helping, people can then reach out to support people and professional services.

## Postvention

**The Way Back Support Service** is a new, innovative suicide prevention service. It has been developed to save the lives of one of the population groups most at-risk of suicide – those people who have attempted suicide. The Way Back Support Service delivers person-centred, non-clinical care and practical support after a suicide attempt. Support Coordinators link people into existing health, clinical and community-based services, to ensure that people are safe and accessing the community-based support that is available. More information is available at: https://www.beyondblue.org.au/about-us/programs/suicide-prevention/the-way-back-support-service

*beyondblue's* **The Way Back information resources** are a set of practical resources for people recovering from a suicide attempt and their families. They feature real-life experiences of people who have attempted suicide or supported others in their recovery. They include:

- *Finding your way back* – a resource for people who have attempted suicide
- *Guiding their way back* – a resource for people who are supporting someone after a suicide attempt
- *Finding our way back* – a resource for Aboriginal and Torres Strait Islander peoples after a suicide attempt

The *beyondblue* website (www.beyondblue.org.au) includes essential information for people bereaved by suicide, along with links to other resources and support organisations. It also includes information on how

to identify and respond to emergency and crisis situations, understanding suicide and grief, and appropriate suicide language.

## Improving the evidence base

*beyondblue* is working to **improve the evidence base** on suicide through supporting research projects that address critical knowledge gaps. Details of *beyondblue*-funded research projects, including information on the researchers, a description of the project, and outcomes, is available on the *beyondblue* website - www.beyondblue.org.au/resources/research/research-projects

 *beyondblue* suicide prevention research projects have included:

- Identification and analysis of health service and pathways to health services contact amongst persons who suicided in Victoria, 2009 – 2010 (2015)
- Doing what comes naturally: Investigation of positive self-help strategies used by men to prevent depression and suicide (2014)
- Fatal suicidal behaviours in LGBTI populations (2014)
- Investigating health and survival outcomes and opportunities for prevention after medically serious suicide attempts in the Northern Territory: A follow-up study of Indigenous suicide attempts and care in the Northern Territory (2014)
- Men's experiences with suicidal behaviour and depression (2014)
- Re-frame IT: A randomised controlled trial investigating the impact of an internet-based CBT intervention among school students experiencing suicidal ideation (2014)
- Ensuring guideline-concordant monitoring of suicidal thinking and behaviour after initiation of antidepressant treatment in 12-to 25-year-olds with depression (2013)
- Depression management and prevention of suicide amongst the elderly in general practice (2007)
- Exploring Melbourne's hidden epidemic: Medication overdose, depression and their management by first responders (2006)
- Reducing Suicide in Men through general practice – The SIM Study (2006)
- **The *beyondblue* National Ambulance project:** self-harm and suicide attempts across Australian Ambulance and emergency services (2015 – 2018).

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# *beyondblue* Position Statement: Suicide Prevention

*"The stigma is crippling, because you can't talk about how you want to begin your life again. People will ask what turned it around. If you say "I tried to die" people no longer see it as a positive experience. Instead you are made to feel ashamed, guilty for what you tried to do in a moment of desperation, after a struggle that other people can't imagine. You can't say "I still think of it" – you are made by society to hide it, like that embarrassing time you got drunk and made a fool of yourself, when it is so much more serious." Suicide survivor*

## *beyondblue*'s position

- **Suicide is a public policy issue** and suicide prevention needs to become a **national priority** in its own right.
- **Suicidal behaviour can and must be reduced** through concerted community and whole-of-government action.
- Actions need to be based on data, research evidence and the experiences of people affected by suicide.
- A range of interconnected whole of population and more targeted strategies should be implemented simultaneously for the best result.
- Individuals and communities with high rates of suicidal behaviour and suicide, such as Aboriginal and Torres Strait Islander people, LGBTI individuals and people living in rural and remote areas, require specific, community led tailored interventions.
- The **reasons behind suicidal behaviours are complex** and can include biological, psychological, social, cultural, spiritual, emotional, environmental and economic factors.
- There are clear links between suicide and mental health conditions and substance misuse, but most people with a mental health condition are not suicidal and not all people who suicide have a mental health condition.
- Strategies for suicide prevention must be person-centred and relevant, requiring engagement with individuals, families and carers. **Support for people experiencing suicidal ideation or who have made a suicide attempt is pivotal** – including interventions for individuals, as well as those who make up close personal relationships – and primary care, emergency departments and specialist mental health services have a crucial role to play. A holistic approach is required that tackles specific factors that are contributing to an individual's suicidality.
- Preventing and responding to suicidal behaviours shouldn't be limited to health settings alone – **non-clinical services, schools, workplaces and communities** all have an important role to play in addressing the psychosocial issues that may contribute to suicide and supporting people at risk.
- *beyondblue* supports a mix of regional and jurisdiction specific strategies and proven national initiatives that bring together government, Primary Health Networks, Local Hospital Networks, non-government organisations and communities to affect local change.
- *beyondblue* supports continued research to **identify knowledge gaps**, trial new approaches and build the evidence base, as well as access to **better data sets** that provide real time, granular information.

In a typical year, about 3,000 people in Australia die by suicide. This is more than **eight people every day**, almost double the national road toll. Tragically, most people who die by suicide are in the prime of their life. Suicide is the leading cause of death for males and females aged between 15 and 44; however, suicide can occur across the whole life span.

Suicide is the **deliberate act of taking one's life** and it is mostly preventable. Suicide can be considered at one end of a continuum, ranging from ideation, planning, and attempts, to death by suicide.

Suicide is ultimately about **overwhelming psychological distress**. People who have survived a suicide attempt report that, rather than wanting to die, they wanted their unbearable pain to end. By and large, suicide occurs when the pain a person is experiencing is greater than the coping strategies they have. If people are supported to find ways to reduce their pain, to resolve the underlying causes of their distress and to find meaning and purpose in their life, they can exercise other choices and **suicide can be prevented**.

Each suicide attempt and suicide has significant **personal and social effects**. People who have survived a suicide attempt may be subjected to misunderstanding and criticism. The stigma associated with suicide attempts can lead to social isolation that further heightens the psychological distress that contributed to the suicidal behaviour. For every suicide there are tragic ripple effects for friends, families, colleagues and the broader community. The effects are immediate and far-reaching – they include feelings of loss and grief, confusion, anger, blame, guilt, shame, distress, and increased personal risk of suicide. Estimates suggest **that each suicide has a direct impact on as many as 200 people to different degrees – for 25 people it causes a major disruption to their life and for 11 it has a devastating impact.** Those impacted include family and friends, neighbours, work colleagues, classmates, teammates, clinicians, first responders, coronial staff, volunteers of bereavement support services and others.

> *"Because of my job for 20 years, I've seen a lot of trauma, but I have never experienced anything more traumatic than the time my daughter tried to take her own life."*
> *Bereaved parent*

> *"I guess what I'm after is to understand. Not why he did it as I don't think any of us could do that. I want to understand why such a beautiful man has left such a dark place in me. I want to understand how I can make me right." Bereaved friend*

Suicide is one of the highest contributors to burden of disease in Australia, only outranked by ischaemic heart disease, stroke and lung cancer. The economic costs of suicide are also considerable and is estimated to be $1.7 billion per year (calculated in 2010). This estimate includes only deaths by suicide and does not include costs related to suicide attempts and suicide ideation. Other estimates suggest that the **cost is close to ten times that amount ($17.5 billion per year)** when other suicidal behaviours are also included.

It is well understood that there is not one single cause of suicide – **it is a complex behaviour with multiple contributing factors, including biological, psychological, social, cultural, spiritual, emotional environmental and economic factors**. There are clear links between suicide and mental health conditions such as depression and anxiety as well as substance misuse; however, **most people with a mental health condition are not suicidal and not all people who take their life have an underlying mental health**

**condition**. Interventions therefore need to be holistic and tackle the specific factors that are contributing to an individual's suicidality.

A simplified approach to considering the causes of suicide is from the perspective of **risk and protective factors**. Risk factors are those things that may increase the chances of someone dying by suicide and can include having a mental health condition, alcohol and other drug problems, abuse or trauma, chronic pain and physical illness, social isolation, unemployment and lack of meaning and purpose in life. **Protective factors are things that may decrease the likelihood of suicide**, such as good coping and communication skills, supportive social relationships, a sense of control of one's life circumstances, financial security, good physical health, and access to supports and services for health and mental health conditions. However, while these risk and protective factors have been found to be important at an aggregate population level, each person's situation is unique and needs to be explored and understood. As such, a focus on risk and protective factors at the population level needs to be complemented by a tailored clinical and psychosocial assessment at the individual level.

The World Health Organisation recognises that the evidence for suicide prevention supports a range of interventions delivered as part of a comprehensive, collaborative, multi-layered strategy. Recent Australian research has proposed that a range of interconnected whole of population and targeted elements should be implemented simultaneously for the best result. A number of supported and emerging interventions are outlined below:

- **Oversight and coordination** – leadership, ownership and accountability and a coordinated national, state and regional approach to prevention.
- **Surveillance** – increase the reliability, validity and timeliness of national data on suicide, suicide attempts and suicide ideation.
- **Means restriction** – reduce the availability, accessibility and attractiveness of the means to suicide (e.g. firearms, high places), and reduce the toxicity/lethal outcomes of available means.
- **Media** – promote responsible and balanced suicide reporting by all media modalities.
- **Awareness** – establish evidence-informed community suicide prevention awareness programs.
- **Stigma reduction** – to change attitudes and beliefs about suicide, promote and normalise the use of mental health services, and reduce discrimination against people using these services. Promote research and campaigns to provide people with the knowledge, tools and permission to talk openly about suicide, while being careful not to inadvertently normalise this behaviour.
- **Training and education** – implement mental health and suicide literacy programs for the broader community, specialised suicide prevention training for general practitioners and other front line health workers, and targeted training for identified gatekeepers (e.g. educators, workplace health and safety officers, police and emergency services, community leaders).
- **Access to services** – promote increased access to comprehensive services for those experiencing suicidal thoughts and behaviour, and build understanding of how these services may support them.
- **Treatment** – improve quality of clinical, evidence-based care, including cognitive behavioural therapy (CBT) and dialectical behavioural therapy (DBT), particularly for borderline personality disorder, through face-to-face and online treatments. Provide assistance to manage or resolve the underlying psychosocial factors contributing to the suicidality.
- **Crisis intervention** – ensure communities have capacity to respond to crises with appropriate interventions and individuals have access to emergency mental health care, including through emergency departments and telephone and/or online support.
- **Continuity of care** – improve the continuity of care and coordination of services for individuals who leave hospital following a suicide attempt.

- **Postvention** – provide care and services to family, friends and carers impacted by a suicide.

It is important that strategies are tailored to the specific needs of groups at particularly high risk such as Aboriginal and Torres Strait Islander people, LGBTI individuals and people living in rural and remote areas.

## What action is needed?

Successful action to reduce the incidence and impact of suicidal behaviours requires action on three main fronts: **prevention, early intervention and support for recovery**. A single intervention on its own is not sufficient to prevent suicide. A coordinated, collaborative and multi-faceted approach is required, coupled with continued efforts to push the boundaries in design, implementation and evaluation of new strategies.

The prevention of mental health conditions is one important strategy for suicide prevention. This needs to be **implemented early in life** through the home, through maternal and child health and other primary care settings, and through educators in early childhood and school settings, as well as across the lifespan.

Recognition of early warning signs by family, friends and colleagues and prompt detection and diagnosis of mental health conditions and suicidality by health and mental health professionals may help to avert a crisis or reduce delays in treatment and support.

**Increasing help-seeking behaviour and improving access to early, effective intervention** is also vital. All suicidal behaviour requires urgent and serious attention, whether there is an underlying mental health condition or not. Individuals should have access to evidence-based psychological treatment and other supports and services that are matched to their needs and preferences, and that address the causes of their psychological distress as well as the drivers of their suicidal behaviour.

This may include face-to-face approaches or e-mental health solutions. Improvements are required in safety planning and follow-up after discharge from hospital or emergency departments in the immediate high-risk, post self-harm/suicide attempt period, and in the longer term. A more **compassionate, culturally safe and optimistic approach to treatment care** is needed, which does not dismiss or judge the person in distress.

Postvention **support is crucial for families, friends and carers** following self-harm, suicide attempt or suicide, to prevent further suicidal behaviours.

### What is *beyondblue* doing?

*beyondblue* is committed to working with others to reduce the prevalence of suicidal ideation, attempts and suicide. We do this through interventions targeted to the prevention of depression and anxiety – which are a contributing factor to suicidality – through our work in the home, schools and workplaces the wider community. We also do this by developing, implementing, evaluating and refining suicide prevention specific initiatives. These include: the *beyondblue* Support Service, The Way Back Support Service, the BeyondNow safety planning app, extensive resources, and through research, advocacy and policy development.

*beyondblue* is a trusted source of information and support on suicide prevention. There were well over 600,000 unique visitors to the *beyondblue* suicide prevention web pages in 2015/16, over 7 million people

viewed our 2015 Facebook post on suicide warning signs and over 700,000 unique visitors accessed the *beyondblue* forum in the same year.

## What do we advocate others can do?

**Individuals and community leaders**

- Everyone should consider learning the skills to look after their mental wellbeing and manage stress, to recognise the early warning signs of suicidal behaviour and know where to seek advice and support. Developing and maintaining social connections is important for everyone, as well as staying involved with activities of interest and hobbies.
- People who experience suicidal thoughts should consider developing a **safety plan**. *beyondblue's* safety planning app, BeyondNow, allows individuals to create a structured plan that they can work through when they experience suicidal thoughts, feelings, distress or crisis.
- In the days, weeks and months following a suicide attempt, individuals, their family and friends can access *beyondblue's* The Way Back resources. These have been developed to provide direct support and guidance during this time. *beyondlbue's* Support Service is also available to provide telephone, text or online chat support, delivered by trained mental health professionals.
- People who have experienced suicidality (including those people with a mental health condition), and their family and friends, can **reduce stigma and discrimination by sharing their stories**.
- Communities can support family and friends who have lost loved ones to suicide; in particular, opportunities for support and open dialogue may be useful.
- Community leaders can advocate on behalf of their community and encourage those affected by suicide to **talk openly about their experiences**.
- Community leaders can undertake recognised mental health and suicide awareness training to provide advice and referral to community members at risk.

**Organisations and communities**

Organisations (including schools, workplaces and health services) and communities can:

- Create **mentally healthy environments**, which promote good mental health and wellbeing.
- **Build awareness of mental health conditions and suicidality** through disseminating information and resources.
- Provide a **safe and inclusive environment,** which supports and encourages people experiencing psychological distress or a mental health condition to seek assistance, allows them to be treated with respect and dignity, and encourages them to participate actively in life, free of stigma and discrimination.
- Consider providing **gatekeeper training**[1] for professionals or community members who may have contact with people experiencing mental health conditions or suicidality.

Organisations can participate in *beyondblue's* KidsMatter initiative (for early childhood services and primary schools), MindMatters initiative (for secondary schools) and HeadsUp program (for workplaces). These programs build awareness of mental health conditions and suicidality and work to create safe, inclusive environments.

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[1] Gatekeepers are individuals in a community who have face-to-face contact with large numbers of community members as part of their usual routine. Training provided to gatekeepers helps them to identify persons at risk of suicide and refer them to treatment or supporting services as appropriate.

**Health and mental health professionals**

Health and mental health professionals have a vital role to play in the prevention and early detection of mental health conditions, in recognising suicide risk and providing referral or active treatment that reduces the risk of suicidality. For the greatest impact, tailored responses across the spectrum of suicidality and risk should be considered, along with holistic, person-centred interventions, not just limited to situations of high or imminent risk. Some health professionals should consider mental health first aid training to equip them with mental health-specific knowledge and skills.

Health and mental health professionals are ideally placed to:
- Empower individuals to understand their mental health better
- Advise how to navigate the health system more easily, by informing people about what services are available and where to turn for support and care
- Provide support and information to the broader care team, including family, friends and carers.

**Primary Health Networks (PHNs)**

PHNs have a critical role in commissioning suicide prevention services. PHNs should consider:
- Commissioning effective, evidence-based suicide prevention interventions that are tailored to the needs of their community.
- The supports and services are available for people in the community following a suicide attempt. The highest risk period to die by suicide is in the first three months after an attempt. Intensive, outreach support during this time could be incorporated as a core component of all suicide prevention models.
- Implementing a tailored and intensive approach to reduce suicide in Aboriginal and Torres Strait Islander people. Ideally, this should harness the strengths and expertise of Aboriginal and Torres Strait Islander leaders and communities, respond to the risk factors and social and economic disadvantage that disproportionately affects Aboriginal and Torres Strait Islander communities, and include both Aboriginal and Torres Strait Islander-specific and mainstream services.
- Implementing an effective community engagement approach, as this can improve the effectiveness, efficiency, sustainability and uptake of suicide prevention initiatives.
- Developing strong governance arrangements to support regional approaches to suicide prevention. Important factors to consider are strong local leadership and control, clear decision-making processes and lines of accountability.

**Researchers**

Researchers have an essential role to play in **increasing and sharing knowledge on effective ways to prevent suicide and suicide attempts**, and to support translation of the existing evidence base into action through clinical practice, policies and community based programs. Preferably, research should be informed by and respond to community needs and input from those with a lived experience of suicide. Research professionals also have a role to play in testing new interventions via pilots, and evaluating existing programs and services. Additional research can:
- Maintain and grow the evidence base
- Improve data sets to ensure access to real time, granular, demographic data to inform policy
- Trial innovative solutions, such as those which use technologies
- Expand the impact of research translation, particularly through support for policy makers.

Researchers should consider aligning their work with the National Suicide Prevention research agenda and advise on ways in which findings can be accessible to community members, beyond the academic cohort.

**People working in the media**

The media has an important role to play in informing public opinion and understanding of people with mental health conditions and people who attempt or die by suicide. Media professionals are encouraged to refer to the Mindframe guidelines – www.mindframe-media.info – which give advice on how to report on suicide without alienating members of the community or **inadvertently contributing to suicide being stigmatised, presented as glamourous, or an option for dealing with problems**. All forms of media should be considered, particularly social media.

**Governments**

All levels of government can work to prevent suicide, through strong leadership and a commitment to suicide prevention. Governments can consider:

- Increasing access to quality assured assessment and evidence-based services that are equipped to manage the whole spectrum of suicidality and not just people at imminent risk.
- Funding national, state-based and community organisations to develop, deliver and evaluate evidence-based suicide prevention initiatives.
- Establishing national, state, or regional indicators and targets to reduce rates of suicide and suicide attempts, and report on progress annually.
- Developing comprehensive, integrated, cross-sector suicide prevention plans with clear governance structures and accountability mechanisms.
- Increasing quality and timeliness of national, state and regional data on suicide ideation, suicide attempts and suicide deaths through appropriate agencies in order to enable evaluation of interventions and tracking of success.
- Supporting the establishment of an integrated, standardised data collection system which serves to identify vulnerable groups, individuals and situations.

## Further information

*beyondblue* has a range of resources to assist organisations and communities to improve awareness of suicide and suicide prevention, and to increase knowledge about depression and anxiety. This information is tailored to the needs of different organisations and communities, and is available at: www.beyondblue.org.au For people who've attempted suicide and those caring for them, information on The Way Back resources is available at: https://www.beyondblue.org.au/about-us/about-our-work/suicide-prevention/the-way-back-information-resources

More information on suicide prevention, including references that support this Position Statement, are available in the *beyondblue* **Information Paper: Suicide Prevention**.