Rural Suicide and its Prevention:
a CRRMH position paper

About the Centre for Rural and Remote Mental Health

The Centre for Rural and Remote Mental Health (CRRMH) is based in Orange NSW and is a major rural initiative of the University of Newcastle and the NSW Ministry of Health. Our staff are located across rural and remote NSW.

The Centre is committed to improving mental health and wellbeing in rural and remote communities. We focus on the following key areas:

- the promotion of good mental health and the prevention of mental illness;

- developing the mental health system to better meet the needs of people living in rural and remote regions; and

- understanding and responding to rural suicide.

As the Australian Collaborating Centre for the International Foundation for Integrated Care, we promote patient-centred rather than provider-focused care that integrates mental and physical health concerns.

As part of the University of Newcastle, all our activities are underpinned by research evidence and evaluated to ensure appropriateness and effectiveness.

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AUSTRALIA

Centre for
Rural & Remote
Mental Health

Message from

His Excellency General The Honourable David Hurley AC DSC (Ret'd)
Governor of New South Wales

It was encouraging to read the headline figure in the recent Australian National Suicide Statistics which tell us that 161 fewer people died by suicide in 2016 than the previous year. This is an encouragement to the communities, health services and non-government organisations that are working hard to prevent deaths by suicide.

Sadly, the headline figure hides a disturbing finding which is that the rate of deaths by suicide in rural and remote communities is about twice that of our capital cities. In Sydney and Melbourne 7.9 and 8.9 people died by suicide for every 100,000 residents in 2016 but the corresponding figure for rural and remote Australia was 15.3.

The figures for our Aboriginal and Torres Strait Islander People are even worse and we need to continue to work with them to address these deaths and bereavements.

The purpose of this short paper is twofold: to describe the problem and to suggest how we might address it based on the best available evidence. The evidence to inform the prevention of suicide in rural areas is not perfect but that should not prevent us from acting. In many areas of life we have to take action based on the best knowledge and we must test those actions to see if they are appropriate.

As Patron of the Centre for Rural and Remote Health, I encourage you to read this document carefully and critically but to work collaboratively to make a difference in rural communities. In previous generations, deaths by suicide were often hidden due to stigma and shame. However, there has been some improvement and I commend this document to you for thought and action.

I encourage you to please contact the Centre for Rural and Remote Mental Health if you wish to contribute to solving this problem – details are at www.crrmh.com.au

General The Honourable David Hurley AC DSC (Ret'd)
Governor of New South Wales

Overview

Rural suicide causes enormous distress to individuals, families, workplaces, and communities and needs to be addressed seriously. We would like to start by expressing our sympathy to all whose lives have been touched by the suicide of a family member, friend or acquaintance.

In 2016, the number of suicides per 100,000 people in rural and remote Australia was 50% higher than in the cities. This rate gets higher as areas become more remote and has been growing more rapidly than in the cities. The rate for Aboriginal and Torres Strait Islander people is twice that for non-Indigenous people.

The **CRRMH** believes that five focus areas are needed to address this situation. Two are for immediate action to prevent suicide deaths (now and into the future) and three are designed to prevent deaths in the future.

The prevention of rural suicide is not the sole responsibility of health services or of mental health services. There are important roles for governments, private sector, health and welfare institutions, rural and remote communities, and individuals.

Figure 1: Rural Suicide prevention Focus areas

We have drawn on research evidence and on the experience of rural stakeholders. We hope that this will help in addressing and reducing these deaths in our rural communities.

Figure 2: Structure of Rural Suicide and its Prevention: a CRRMH position paper

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This paper has two purposes: to draw attention to the unacceptable rates of rural suicide and to suggest where we should focus our attention if we are serious about making a difference.

Background

On the 11th of April 2017, the **CRRMH** held a Rural Suicide Prevention Forum. The Forum was opened by His Excellency General The Honourable David Hurley AC DSC (Ret'd), Governor of New South Wales. Senior representatives of key stakeholder organisations were invited to hear presentations from academic, service provider, Aboriginal and Torres Strait Islander, and small community resident and suicide prevention experts. Primed by these talks and a briefing paper [1], group discussions followed to obtain the insights and ideas of those attending. The **CRRMH** regards the Forum as an important first step in preparing the current position paper, and we trust that those in attendance will recognise that their contributions did much to inform the positions we are proposing.

Figure 3 below describes the key messages participants took from the Forum. Whilst this Position Paper summarises the latest evidence on rural suicide prevention it is important to recognise the thoughts, ideas and experience of those living in rural communities and working in the mental health system. Their experience is most important in improving rural suicide prevention.

Figure 3: Summary of Rural Suicide Prevention Forum key messages

Create Hope and Focus on Wellness
- Use language that welcomes people, not alienates. Messaging should be about wellbeing, rather than always using 'mental' and 'suicide'
- We have the assets, we have the resources, we have the goodwill – getting all of these on the same page with a common agenda will deliver better quality, more focused and better resourced solutions
- The "ripple effect" in rural communities may deepen the impact of suicide, but can also be used to strengthen prevention
- Go upstream – build strength, resilience and hope in communities

Develop Community Capacity and Capability
- Establish a mentoring program to develop community leaders for rural suicide prevention
- Build on and use the strengths and knowledge in the local community and the many passionate people working to make a difference
- Invest in training, developing and supporting our local workforce and leaders so that knowledge and capacity stays in the community

Educate our Next Generation
- Invest in school-based mental health promotion prevention and early intervention
- Education, education, education when they are young

Recognise the Diversity of Rural Communities
- "Go the extra mile" with communities experiencing intergenerational trauma e.g rural Aboriginal communities
- Consult and look at the strengths of a community and harness them
- Recognise the importance of community identity and local circumstances... there are communities within communities

Why focus on rural suicide ?

"When you've seen one rural town…
you've seen one rural town." (Anon.)

Stories and images of rural Australia have played an important part in the formation of the country's national identity, even though most Australians live in capital cities (66%). Often the impressions of rural life held by those living in cities are romanticised and outdated, drawn from popular nineteenth and twentieth century sources such as the poetry of Banjo Patterson, Henry Lawson and Judith Wright.

Rural communities are diverse and vary in size, location, proximity to other towns and regional centres, population dispersion, culture, ethnicity, and other demographic factors. Planning for the prevention of rural suicide at the local and regional level needs to take this diversity and variation into account.

Rural communities play a critical role in the economic prosperity of Australia, with 67% of the value of Australia's exports coming from regional, rural and remote areas and with 45% of tourism spending occurring outside Australia's capital cities. The location of rural communities is usually tied to economic drivers such as amenable climate, the resource availability (such as water, pasture, fishing, minerals), and access to transport routes. Over time, these drivers may come under tension (land and water use for agriculture versus mining) and change due to factors such as prolonged drought, resource depletion, or the relocation of local industries (such as abattoirs and food processing plants). Consequently, rural communities change in terms of their prosperity, viability and sustainability.

Rural communities also vary in their level of attractiveness and lifestyle possibilities, with some locations providing favourable conditions for primary industry, mining and tourism. Rural communities that can offer an attractive lifestyle may be successful in increasing investment and diversification of jobs in the service sector and other support industries.

All rural communities face the threat of periods of adversity due to natural events (such as fire, flood, and drought). When these occur, the wellbeing and economic security of rural communities are negatively impacted often for prolonged periods and thus long-term uncertainty and population decline may ensue. It's important to consider that whilst alternative employment may be available locally in large cities, rural communities may depend on fewer employers, and thus job loss due to adversity (commodity price reductions or poor weather) all may have a disproportionate effect. Periodic adversity has an impact on the wellbeing of rural communities and needs to be addressed in planning for rural suicide prevention.

Outside large regional centres there is often a shortage of resident medical and allied health specialists such as psychiatrists, psychologists and mental health nurses. In more remote areas, there may be a shortage of generalist health providers such as general practitioners (GPs) and community health nurses. Many rural health services are affected by a relatively high staff turnover, inexperienced staff, thin supervision and extended periods during which positions are not filled.

The provision of adequate health services in rural and remote areas is clearly an important place to start when planning to reduce rural suicide. The impact of such inadequacies in service provision has already been demonstrated with studies showing that in rural and remote areas there is a higher prevalence of risk factors for chronic illness, higher death rates and lower uptake of treatments for mental illness (although it is acknowledged that this is an overall fact and that some rural communities may have very different indicators). It is not surprising then that the rate of suicide outside our capital cities is more than 50% higher than within them.

> It should be acknowledged that there are localities in rural and remote areas where the suicide rate might be very low. A recent study shows that rural suicide is not a homogeneous phenomenon. This heterogeneity suggests that local, placed-based factors (social, economic etc.) may be more important drivers of psychological distress, poor social and emotional wellbeing and suicide than mental illness.

The diversity and variability of rural communities suggests that those who plan and provide services for those living in rural and remote Australia need to treat the prevention of rural suicide as a complex endeavour. Furthermore, the diversity and complexity of factors impacting on rural suicide illustrates the need to think flexibly about what should be different for the prevention of rural suicide, compared with strategies currently accepted as successful in metropolitan areas.

> We take an aspirational position that rural suicide can be prevented. This paper puts forward concrete suggestions about how rural suicide can be reduced in the short, medium and long term.

Suicide prevention for rural localities should begin with an assessment of the characteristics, needs and capacity of the local community.

Rural health and wellbeing

The health status of rural Australians

"The health of Australians in rural and remote areas is generally poorer than that of people who live in major cities and towns."

Commonly cited reasons for this poorer health status include substantial differences between the metropolitan and rural and remote populations in exposure to the social determinants of health.

Some of the social determinants of health listed above are not exclusively rural. However, in rural and remote communities, the health effects of these factors are further compounded by poor access to public transport and communications (such as broadband, mobile coverage), and environmental challenges (such as droughts, floods, and bushfires).

Figure 4: Social determinants of health and the health status of rural Australians [2]

Social Determinants

• lower levels of income, employment and education
• higher occupational risks, particularly associated with farming and mining
• geography and the need for more long-distance travel
• poorer access to fresh foods
• poorer access to health services

Poorer Health Outcomes

• higher mortality rates and lower life expectancy
• higher reported rates of high blood pressure, diabetes and obesity
• higher death rates from chronic disease
• higher prevalence of mental health problems, including dementia
• higher rates of alcohol abuse and smoking

Rural mental health

National surveys indicate that the prevalence of the common mental illnesses is similar across the country (around 20%) [2].
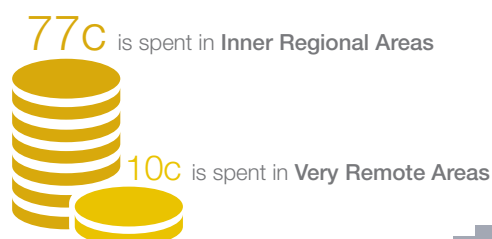
However, the impact of mental illness on the lives of rural residents is greater due to differences in access to, and uptake of, effective treatments and services. Figure 5 shows the differences between major cities and other areas in access, utilisation and mental health spending. It shows that the burden of having a mental illness falls more heavily on those who live in more remote areas of the country.

Figure 5: Access and utilisation of mental health services in rural and remote areas compared to major cities.[1]

GP Mental Health Encounters...

Major Cities 708.5 (per 1,000 people)

Rural & Remote Areas 339.2 (per 1,000 people)
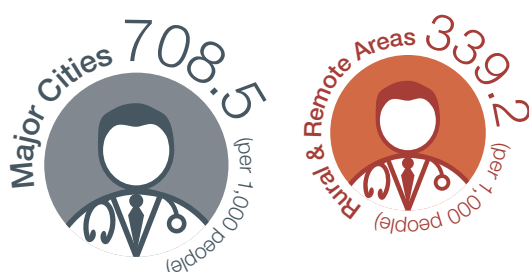
For every $1 spent per capita on Medicare mental health services in Major Cities...

77c is spent in **Inner Regional Areas**
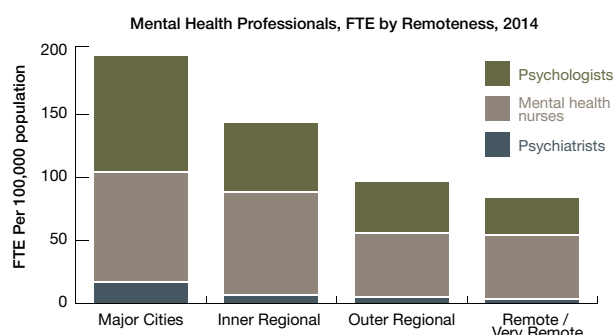
10c is spent in **Very Remote Areas**

If you live in a Major City you are...

2x more likely to have **accessed a psychologist** in the past year than in other areas

The number of Mental Health Professionals decline with remoteness…

Mental Health Professionals, FTE by Remoteness, 2014

FTE Per 100,000 population

- Psychologists
- Mental health nurses
- Psychiatrists

Major Cities | Inner Regional | Outer Regional | Remote / Very Remote

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"Timely diagnosis, treatment and ongoing management of mental health conditions in rural and remote areas is likely to occur later or not at all, often resulting in an increased likelihood of hospitalisation and sometimes leading to the most tragic of outcomes - self-harm and suicide" [2]

The burden of mental illness also falls on those who live with, know or care about a person with a mental illness in a rural setting. They experience frustration about poor access to services, and the burden of assisting the ill person to access treatment when it is available (often at some distance in a regional centre), and the effort and cost of visiting while they are in hospital can be high. Concern about the ill person's social isolation and possible access to the common means of suicide (medical drugs, poisons etc.) when at home may also be a great stressor for rural carers.

Particular risks in rural settings

People living in rural areas experience unique circumstances that can increase the risk of ongoing mental ill-health and suicide, especially if emerging problems are not recognised and addressed.

For many living in rural and remote areas, their economic security is somewhat out of their control and hence they experience higher levels of insecurity than those who live in cities, who might have greater opportunities to gain employment and provide for themselves and their families.

For those who own, manage and work on farms, their security depends very much on the variability of the seasons. Even when seasonal conditions suggest a hopeful future, their personal experience reminds them of the realistic risk of future adverse conditions, such as too much or insufficient rainfall, too high or too low temperature, hail, frost, fire etc. This causes prolonged periods of stress and an inability to celebrate success until financial benefits are fully realised. In addition, even the income from successful farming yields is dependent on the external market at the time of sale.

This uncertainty extends to those whose livelihoods depend on the prosperity of farming, with many small businesses relying on being paid sometime in the future, if, and when there is a successful season. One business woman, whose small town is losing its retail businesses, said that she feels powerless because:

"I can't spend money in the town until I get paid, and I'll get paid (hopefully) when the farmer does".

[1] Generated using information from the National Rural Health Alliance 2017 [2] based on multiple sources

While there is considerable literature on the threats to the mental health of workers who drive, or fly to work at mines, it must be remembered that there are also many occupations associated with agriculture (such as truck drivers and shearers) that involve workers being away from their home for long periods of time, with increasing risks to health and mental health.

A further stressor in many rural communities is the actual or planned change in the economic basis of their community, including tensions over the competing interests in how the water and land should be used. On the Liverpool Plains for example, there is great concern being experienced by some who do not want any expansion of the coal seam gas industry, while at the same time others are greatly concerned about the decline in small towns and see the new jobs as necessary for the future of the region.

Rural decline is a further consideration, especially for those without the option of moving to a more prosperous location. They may witness the gradual closure of small businesses in nearby small towns and see they are going to face increasing costs for essential services. Rural decline weakens both the economic and social capital of the area.

A further consideration is the reluctance of many rural residents to utilise support services when their circumstances lead to feelings of anxiety or depression. Apart from the reluctance to admit that they may have a problem there is also the perception that services may not prove to be helpful.

"Reluctance to expose their private lives to strangers or acquaintances from locally based services, or to undertake the journey to distant services where cultural or behavioural differences could be misunderstood, may impact on rural dwellers' wellbeing." [3]

The positives of a rural lifestyle

"People in rural areas regularly score better than their major city counterparts on indicators of happiness. This may be testament to the positive aspects of rural life, and the interconnectedness of people living there. In rural areas, there are higher levels of civic participation, social cohesion, social capital, volunteering and informal support networks from neighbours, friends and the community." [2]

Characteristics such as these are an important platform upon which to build a strategy to reduce rural suicide.

Resilient[2] communities demonstrate the strength of their underlying social capital when they need to cope with downturns in economic capital and the effects of natural disasters and other impacts on their environmental capital. In less populated rural areas, with greater social isolation, the social capital may not be sufficient to adequately cope with adversity.

This community resilience is critical to the resilience of individuals and families who belong to that community. While in the short-term communities may need outside help to cope with certain negative circumstances, their longer-term resilience will be enhanced by the extent to which those outside resources complement and enhance local capability.
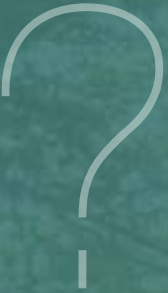
While generalisations such as these are supported by population-level research, they disguise the fact that these benefits may not be experienced equally by everyone and everywhere in rural areas. Consequently, efforts should be made to challenge and support rural communities to extend social connectedness, and to reduce the exclusion of some individuals based on their race, culture, sex, sexual preference, income or location.

Rural settings also hold the potential for powerful collective planning and problem-solving efforts and this may be harnessed to address the problem of rural suicide.

"Rural and small-town settings offer unique opportunities for inter-professional collaboration and the engagement of different elements of local society, including indigenous communities, economic interests and broader elements of civil society. While networking and partnering are possible in any health service environment, we contend that rural environments offer a much less cluttered setting in which to observe the processes and outcomes of primary health care development." [5]

Building strong resilient rural communities is an important investment to ensure that such communities can support the most vulnerable in times of adversity and those who may experience suicidality.

2 "Resilience" is the capacity of an individual, organisation or community to adapt successfully to change and to the onset of adverse circumstances or trauma.

How can we understand suicidality

In plain terms, a suicide is the result of a deliberate act by a person with the intention that the act would lead to their death. Both the **deliberate** nature and the **clear intention to die** are key definitional requirements.

The term "suicidality" in this paper refers to a state in which a person has thoughts about suicide, or forms intentions, or develops plans, or enacts suicide-related behaviours such as intentional self-harm (though not all episodes of intentional self-harm directly relate to suicidality).

Unlike other causes of death, we remain puzzled to explain how a person can be in such a state that they want to take their own life. The fact that suicide is so different to other so-called "health issues" is illustrated by the fact that it has been studied in such vastly different disciplines as etymology, biology, genetics, sociology, philosophy, history, medicine, psychology and psychiatry.

Collectively, these disciplines see suicidality as having its origins in the person's early life experiences which will be discussed later in this paper. These origins interact with other interpersonal, environmental and societal influences in complex patterns over many years" [6]. (see Appendix 1 for a full description of three prominent theories on suicide)

What do we know about rural suicide?

FACT 1
Suicide rates in rural and remote areas are higher than in major cities

FACT 2
Suicide rates are progressively higher in rural, remote and very remote areas

The first thing we know is that the rate of suicide outside of the Greater Capital Cities is much higher than in areas inside of the Greater Capital Cities.

The most recent annual data on suicide in Australia was for the year 2016 and was published in September 2017 [7]. It showed that in 2016:

- The overall suicide rate for the whole of **Australia** was **11.7** per 100,000
- The rate of suicide in all of Australia's **Greater Capital Cities** combined was **10.0** per 100,000
- The rate of suicide for the combined **areas outside** the Greater Capital Cities was over 50% higher at **15.3** per 100,000
- The number of deaths outside the Greater Capital Cities comprised **42% of suicide deaths in Australia.**

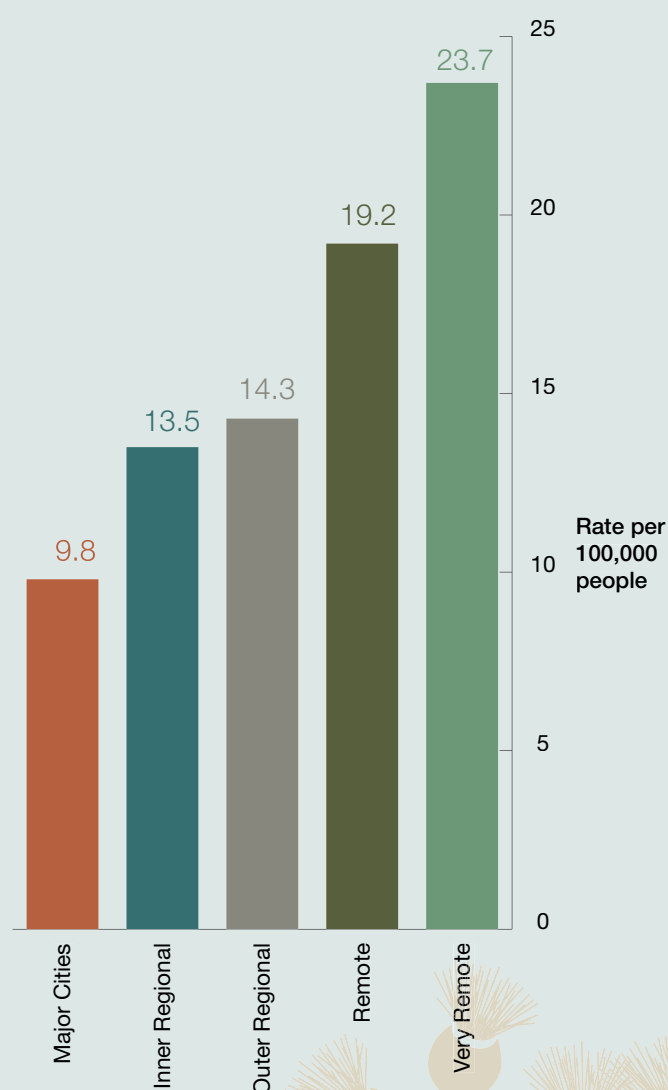**Figure 6: Suicide rate, by region of usual residence, Australia, 2016 [7][3]**

The data on suicide and self-inflicted injuries in Australia shows that as locations become more remote there is an ever-increasing death rate from such causes (see Figure 7 [8]).

Figure 7: Death rates, suicide and self-inflicted injuries, Australia 2010-2014 [8]

National and State policy to prevent suicide in Australia must take into account that suicide rates outside the Greater Capital Cities is much higher than those within.

[3] The Australian Bureau of Statistics does not publish suicide data for the rest of the territory for the Northern Territory or the ACT in the table from which these data are derived.

Data also published by the Australian Bureau of Statistics (ABS) shows that the rate of suicide has been rising more sharply outside of the Greater Capital Cities during the period 2012 to 2016 compared to the rates for the Greater Capital Cities (see Figure 8).

Figure 8: Suicide rates by region, 2012-2016, Australia, 2016 [7]

Rate per 100,000 people

— Rest of States total
— Australia
— Greater Capital Cities total
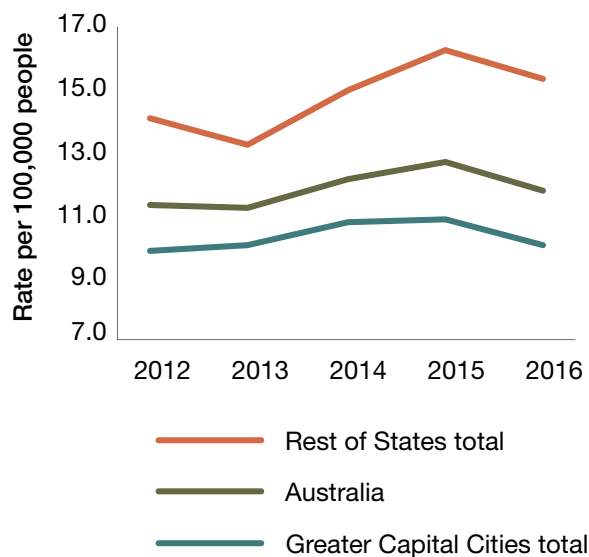
Suicide rates have increased in Australia by **4.5%** from 2012 to 2016. In the Major Capital Cities Statistical Local Areas (combined) rates rose by a much lower rate of just **2%**, while in areas outside the capital cities, they rose by a significantly higher rate of **9.2%**.

> Suicide rates are rising more sharply in areas outside the Greater Capital City Statistical Areas.
>
> Suicide prevention policy and strategies must address the factors that account for this pattern. The solutions may differ from those that seem to be working in the capital cities.

In 2016, the final report of the Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Report was released providing guidance for future work on suicide prevention in Aboriginal and Torres Strait Islander populations. The following is an excerpt from the Executive Summary of the report.

> "Suicide has emerged in the past half century as a major cause of Indigenous premature mortality and is a contributor to the overall Indigenous health and life expectancy gap. In 2014, it was the fifth leading cause of death among Indigenous people, and the age-standardised suicide rate was around twice as high as the non-Indigenous rate.
>
> Indigenous children and young people are particularly vulnerable, comprising 30% of the suicide deaths among those under 18 years of age. In addition, Indigenous 15–24 year olds are over five times as likely to suicide as their non-Indigenous peers.
>
> 'Suicide clusters', or a series of suicide completions and/or self-harming acts that occur within a single community or locale over a period of weeks or months, is also a significant concern, particularly among younger people.
>
> As males represent the significant majority of completed Indigenous suicides, gender can also be understood as a risk factor. However, the number of suicides and increasing self-harm among Indigenous females is an ongoing concern." [9]

From 2001 to 2010, the standardised death rate for suicide among Aboriginal and Torres Strait Islander people was **21.4** per 100,000 compared to **10.3** per 100,000 for the non-Indigenous population [10].

From 2012 to 2016 the rate of suicide for the Indigenous population was **23.7** per 100,000. This was more than twice the rate as for non-Indigenous Australians over the same period **11.6** per 100,000 [7].

From 2001-2010, the majority of suicides among Aboriginal and Torres Strait Islander people occurred outside of capital cities. This is in complete contrast to non-Indigenous suicides, the majority of which occurred within the capital city (based on data from NSW, QLD, SA, WA and NT) [10].

Figure 9: Number of Suicides by Geographic Region and Aboriginal Status 2001-2010 [10]

Aboriginal or Torres Strait Islander People suicides

- Rest of State / Territory
- Other Urban
- Capital City

Non-Indigenous suicides

- Rest of State / Territory
- Other Urban
- Capital City
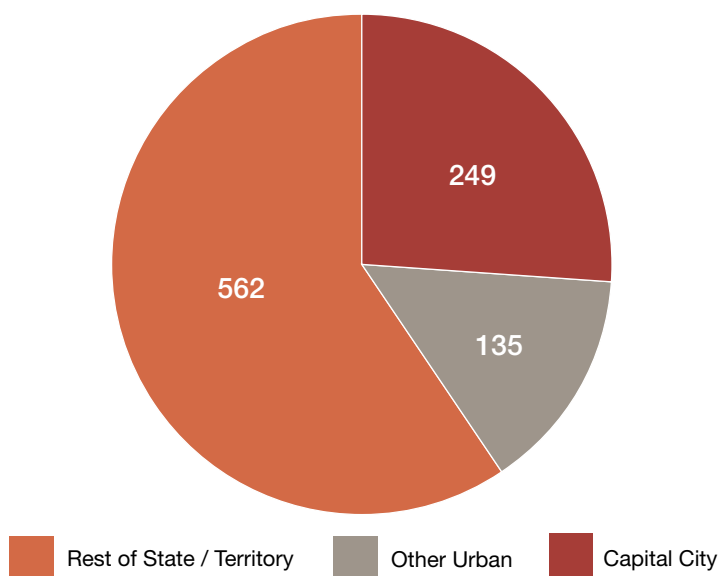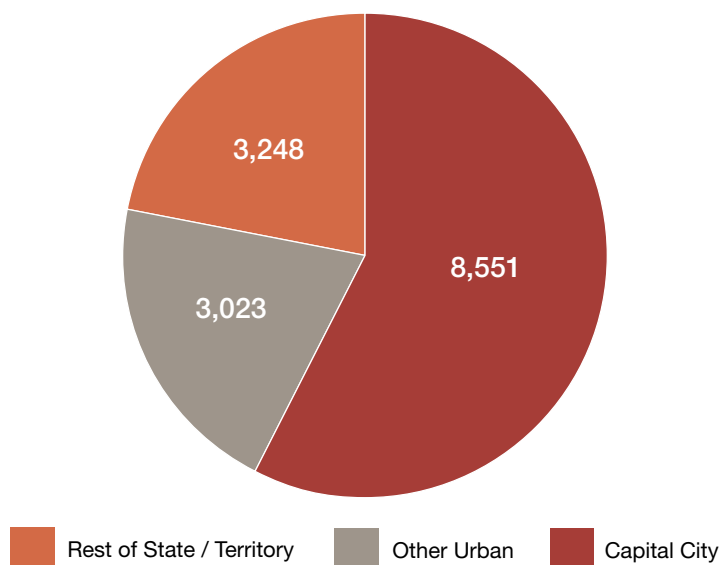
To reduce the suicide rate among Indigenous Australians, specific policies need to be developed to account for the high proportion of Indigenous suicides that occur in rural and remote communities.

Much has been written about suicide by farmers. Nevertheless, it is difficult to draw any firm conclusions from the combined findings because of the way in which the occupation of 'farmer' is inconsistently defined. Is it the person who owns a farm, a person who manages a farm, a person who works on a farm or a person whose livelihood depends on farming?

A recent Australian study [11] analysed previous studies about suicide rates in various occupations. While it concluded that "significantly elevated risk was also apparent in farmers and agricultural workers" it also noted the limitations of their paper:

"There was also a large amount of heterogeneity between studies, which is likely because of inherent differences in how occupation was defined and classified, variation in when the study was conducted, and the social and geographical context of the study." [11]

It is quite possible that rural suicide is a problem across other occupational groups in rural areas, particularly those which involve lesser-skilled occupations, seasonal workers, and itinerant workers.

A recent study from New Zealand [12] examined coroner's records for 185 deaths in farm and agriculture related occupations and showed some interesting findings:

- Only one person was unemployed at the time of their suicide
- There were twice as many deaths of farm labourers as of farm owners or managers
- 91.8% were male
- Mean age was 41
- One in five were recently separated or divorced
- One third of those who died lived alone
- The most common precipitating condition was mental illness (28.6%) and mental illness was also frequently found in cases where there were other precipitating conditions
- The risk factor profile for these suicides was like non-farm suicides.

Various other rural industry leaders have approached the **CRRMH** concerned about the welfare of their workforce. Examples include; primary industry workers, environmental inspectors, workplace safety inspectors, saleyard owners, and stock and station agents. Those who provide services to farmers can often be highly stressed by their frequent contact with stressed and distressed farmers, particularly when they are affected by natural and man-made adverse events.

The **CRRMH** has provided workplace training for managers in the mining sector, and for quarry managers and owners.

A further complication is that those who work primarily in farming frequently work in other occupations, such as nursing, teaching, mining etc. and many farmers have a quarry on their farms as well.

The impact of rural stress extends beyond those who own and work on farms.

Further research is needed to understand the mental health status of other occupational groups whose work is related to providing services in rural and remote areas.

It has often been said that rural men are less likely to ask for help when at risk of suicide than those in cities, but the main difference may lie more in how they ask for help and who they ask.

Griffith University researchers examined the Coroners' records for male suicides in Queensland from 1990 until 2012. They looked specifically at whether or not the person who died had told anyone of their intention to take their own life. Telling someone is a form of help-seeking in that it could indicate that "I need help" rather than "I need a service to help me". The researchers concluded:

"The current findings do not support the expectation that suicide among rural men in Queensland would be characterised by lower levels of communication of suicidal intent than suicide among men in major towns." [13]

The implication of this is that the provision of "gatekeeper training"[3] should be provided to those occupational groups to whom rural men may express suicidal intent.

This research also indicated that the appropriateness and effectiveness of health services used by rural men should be a key priority in efforts to reduce rural suicide.

Apart from population data about suicide deaths, there is little epidemiological research about rural suicide. Many studies into the risk and protective factors for suicide have not included an adequate rural sample. Planning and policy making is informed by studies conducted in densely populated areas. When planning for the prevention of rural suicide, no assumption should be made that research findings will be applicable in rural areas.

Further, many but not all studies conducted in rural areas do not make a comparison to urban populations. Similarly, there are fewer studies of interventions in rural areas compared to those undertaken in major cities.

"It is clear that although there is a strong interest in understanding rural suicide, and despite many coordinated efforts toward its prevention, the field of suicidology still has a great deal to learn about the phenomenon of rural suicide". [14]

There needs to be a greater investment in research to understand suicide epidemiology in rural and remote areas.

[3] The term "Gatekeeper Training" refers to courses designed to increase the knowledge and skills of professionals and others in a community whose role frequently brings them into contact with vulnerable people who may be at risk of suicide. The role of a "gatekeeper" is to watch out for warning signs or conversations that indicate that a person may be under considerable stress and therefore at risk of suicide. They are trained to have a safe and helpful conversation with the person who they are concerned about, and, depending on the results of their conversation to offer assistance appropriate to the seriousness of the person's risk.

What can be done about rural suicide ?

Although still a relatively rare event comprising one in every 5,000 deaths in Australia in 2016, the unique nature of suicide calls out for a serious attempt to prevent it. Suicide is often seen as either a personal choice or a mental health problem, and this leads many people to believe that suicide is difficult to prevent.

Any suicide is unacceptable, especially if the person's risk of death is not recognised and they have not had access to a range of medical, psychological and social support services to prevent their desperate act. Further, when the number of people choosing suicide increases in most years, there is an imperative to make considered efforts to turn this trend around.

This paper advocates that a plan to prevent rural suicide should be based on helping those who are affected by suicide right now, and address the individual, relationship, community and environmental factors that protect against suicidality and those that increase the risk of suicide.

We propose that rural suicide prevention should be comprised of five focus areas for action designed to save lives now and to lower the number of deaths and rates of suicide increasingly over years to come. These recommended focus areas draw on the ideas and suggestions obtained from participants at the Rural Suicide Prevention Forum in April 2017, local and international sources, and our own experience and research.

Five focus areas for rural suicide prevention

In this section of the paper, each of the focus areas are described with suggestions on what suicide prevention efforts might be worth trying in the immediate, medium and long term. Figure 10 outlines these five focus areas and the order of priority that should be given to each.

Figure 10: Five focus areas for rural suicide prevention

Strategies for immediate action to prevent suicide deaths

Strategies for medium to long term reduction in deaths and rates

1 Prevent people who experience suicidality from taking their own lives

2 Help those who are affected by suicide

3 Provide support to vulnerable groups

4 Build protective factors in children and young people

5 Build heathy and resilient people and communities
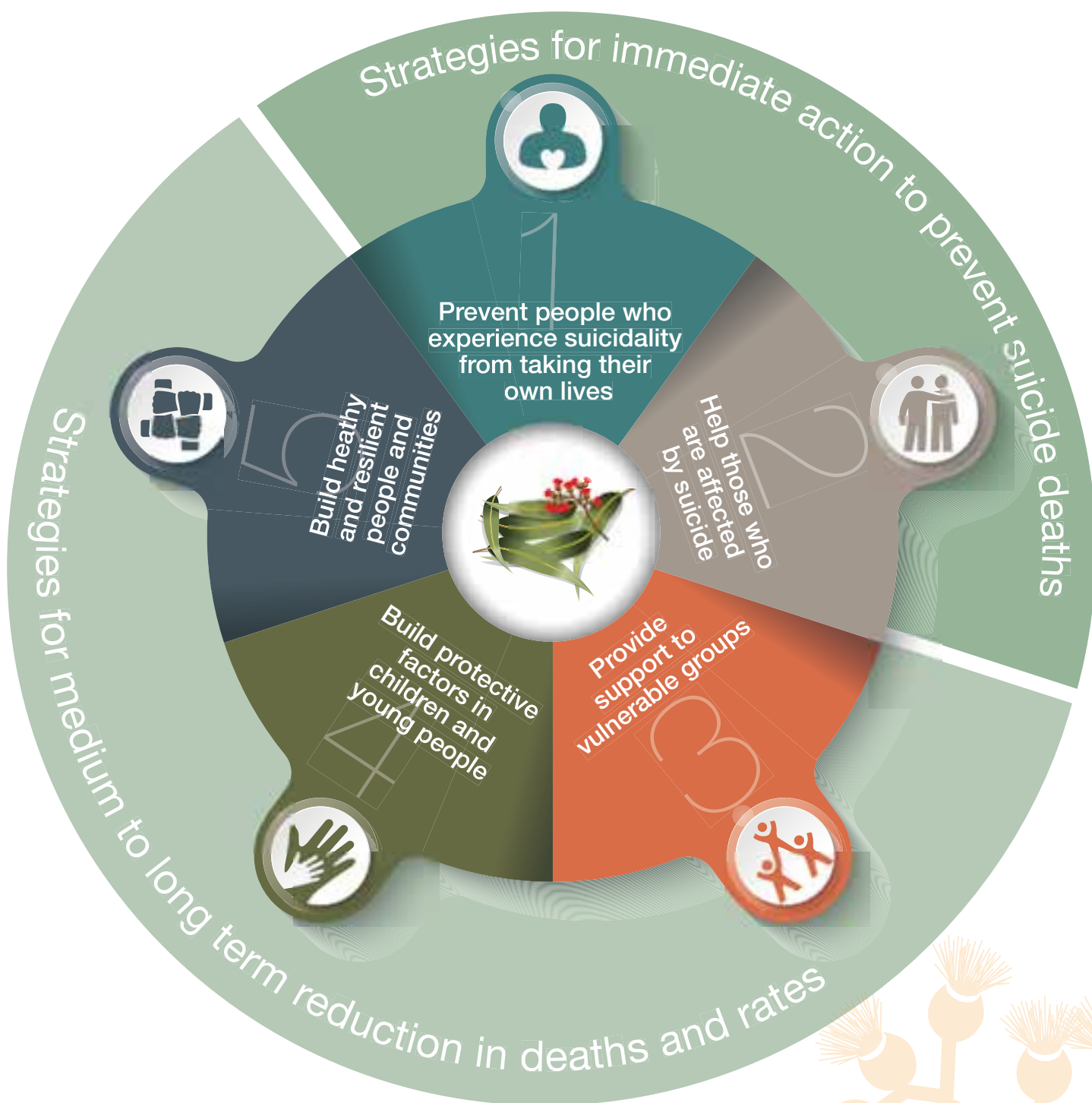
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People who attempt and those contemplating suicide are at much higher risk of death by suicide than those who do not experience suicidality.

National and state suicide prevention policy must prioritise reducing the inequality of access to high quality emergency care, primary health care and mental health services (including those provided by both government and the private sector) experienced by rural people.

The **CRRMH** recognises that the devolution of planning responsibility for mental health and suicide prevention to Primary Health Networks (PHNs) provides the opportunity for joint planning to identify and address gaps in the provision of health and mental health care to those who have attempted suicide (and to those most at risk of suicide).

Care for those who attempt suicide should not stop after they are discharged from hospital or the GP's surgery. Risk of further suicidal behaviour will continue for the person's lifetime and should remain an issue of evaluation for GPs as part of the patient's long-term health care. There is a need for short, medium and longer-term actions for people who make a suicide attempt or who self-harm.

Preventing suicide has an immediate and a long-term component. A patient saved from death from a massive heart attack will need lifetime care and support. The same is needed for patients saved from death by suicide. The implication is that a management plan, spanning years, is needed for successful prevention. [15]

Rural people who attempt suicide should be given the same level of health information when they are discharged as would be the case for a patient presenting with other serious health conditions (such as heart and respiratory conditions or diabetes). The provision of health information to patients on discharge is part of normal care for many acute health conditions. It would be helpful if standardised patient education resources could be developed by state health departments which could then be tailored by local health authorities and PHNs to include locally relevant information and the availability of services.

Health information should also be provided to family members and close friends, including how they may support the patient after they are discharged and what to do in a crisis.

People who have made a suicide attempt but do not need emergency treatment, should nonetheless be encouraged to discuss their attempt with a GP who can then develop a plan for further assessment, treatment and follow-up care.

Professional development training in suicide risk assessment needs to be made accessible to rural general practitioners and other health professionals. Students in medicine and allied health disciplines should also be given relevant training before they commence rural placements.

Rural schools should be provided with information, advice and practical assistance to support those affected by a suicide attempt in their school community.

Similar access to information, advice and assistance should be made available to rural workplaces, possibly through work safety authorities in states and territories, to support the return to work of people who have made a suicide attempt (especially those who will require support from work to attend follow-up appointments with health professionals). Return to work coordinators also need to receive specific training on how to provide adequate support for those who have attempted suicide and require transition back to work.

Programs that provide social support by lay people, such as the Way Back Service (currently being trialled by *beyondblue*) should also be provided in rural and remote Australia.

A suicide awareness campaign should be designed, evaluated and then implemented in rural and remote areas. The campaign should encourage rural people to reach out to those friends, neighbours, work colleagues and others who have made a suicide attempt.

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1. **Preventing people who experience suicidality from taking their own lives – what might work?**
   a. Provide sufficient funding to ensure adequate health and mental health services are accessible in rural and remote Australia
   b. Take joint action at the regional level to plan and provide adequate health and mental health services in rural and remote Australia, tailored to local needs
   c. Ensure best practice emergency care is available for those who make suicide attempts in rural and remote Australia
   d. Provide long-term follow-up care for people who make a suicide attempt or are thinking of suicide
   e. Provide high quality health information for people who make a suicide attempt or self-harm and for their family and friends
   f. Provide professional development for all rural GPs
   g. Provide guidelines for health care practitioners in rural areas so that they will encourage those who have made less injurious suicide attempts to seek appropriate health care
   h. Provide follow-up social support programs for people who attempt suicide or who self-harm
   i. Provide support for rural schools and workplaces to support those who have made suicide attempts
   j. Increase suicide awareness in rural and remote Australia

Identifying and preventing suicidality in health care settings

On average, 45% of suicide victims had contact with primary care providers within one month of suicide. Older adults had higher rates of contact with primary care providers within one month of suicide compared with younger adults. [16]

The evidence that a large proportion of people who die by suicide have seen a GP or other health practitioner in the weeks leading up to their death suggests that these patients may be experiencing suicidality at the time of their visit. A more concerted effort needs to be made in health care settings to ask patients about suicidality.

Regional health authorities should ensure that rural health staff are adequately trained and resourced to identify and provide a high standard of care to those who present with suicide ideation or a suicide attempt. Guidelines developed by the Black Dog Institute [17] are one example that could be considered for adoption in emergency departments in rural areas, or the Suicide Risk Assessment and Management in Emergency Department (SRAM-ED), developed by the Queensland government:

Queensland Centre for Mental Health Learning

Suicide Risk Assessment and Management in Emergency Department (SRAM − ED)

SRAM–ED is a training package developed by the Queensland Centre for Mental Health Learning. It is comprised of foundational and advanced components to improve the capability and capacity of staff working in EDs to safely and effectively recognise, engage and respond to people experiencing a suicidal crisis. Specifically, SRAM − ED aims to:

- − Increase participant awareness of personal reactions to suicidal people and their impact on practice
- − Increase participant capacity to develop a therapeutic alliance with a suicidal person
- − Increase knowledge and skills in suicidal risk assessment and management with the context of an emergency department.

The valuable insight of lived experience is incorporated into this training via an Advisory Group comprising service users and carers.

While the US Preventive Services Taskforce does not recommend screening for patients with no present symptoms of emotional distress or no obvious risk factors for suicide, it does indicate that, if there are other risk conditions, then risk assessment might be appropriate. Examples might be patients whose medication could be lethal in overdose, such as those being treated for drug and alcohol problems, those with chronic pain, or those with a terminal illness. The need for assessment might be more important when the patient is experiencing acute stressors (such as relationship breakdown or loss of income). This may be particularly important for rural patients as they may have relatively fewer opportunities to be identified as experiencing suicidality.

Expert advice is needed to develop guidelines about who might be periodically assessed in rural settings, what might indicate the need for assessment and the frequency at which they should be assessed. Guidelines should be provided to all health practitioners in all rural health settings.

1. **Identifying and preventing suicidality in health care settings – what could work?**
   k. Undertake an expert advisory process to identify which patient groups should have periodic screening
   l. Provide a periodic assessment of suicidality for patients with known risk conditions for suicide as part of their ongoing care
   m. Provide professional development for all rural GPs, practice nurses, and relevant allied health professionals in the assessment and treatment of suicidality

Identifying the presence of suicidality in the community

The early detection of suicidal thoughts and behaviour, and effective care for those of us who are at risk, are crucial in ensuring that people receive the care they need and deserve. [17]

If people who experience suicidality can be identified (either in the family, the workplace, the school, or in the community), an opportunity is provided for them to receive effective and evidence-supported interventions which may prevent further suicidal behaviour.

Gatekeeper training programs aim to enable participants to ask about suicide by increasing their understanding of the signs of suicide and by providing a safe learning environment in which to practise. When a person is identified as being at risk, the gatekeeper is urged to assist them to access the most appropriate services, ranging from emergency telephone services ('000'), the local hospital, the mental health service, primary health care, or telephone mental health services.

While gatekeeper programs targeting the general community are justifiable, those who have contact with more high-risk people should be given priority. These include "front-line" occupations such as police, ambulance, rescue workers and prison officers.

Gatekeeper programs vary in their content, educational approach and length of delivery. The 2-day Applied Suicide Intervention Skills Training ("ASIST") is the most comprehensive program.

How to help people who are experiencing suicidality is also addressed as part of the 2-day Mental Health First Aid Course, and a range of half-day and one-day training products have been developed and are being implemented by several organisations including Lifeline and Wesley Mission.

The CRRMH has developed "Good SPACE", a 4-hour gatekeeper training program. "SPACE" is an acronym for "Suicide Prevention through Awareness, Courage and Empathy". This workshop is designed to address the training needs of communities in rural, remote and very remote areas.

Workplaces might be encouraged to ensure that their staff who work in a middle management, supervisory or human resources role undertake periodic training that includes increasing knowledge and skills to identify those who may be experiencing suicidality.

"Gatekeeper training programs" aim to enable participants to ask about suicide by increasing their understanding of the signs of potential suicide and by providing a safe learning environment in which to practise.
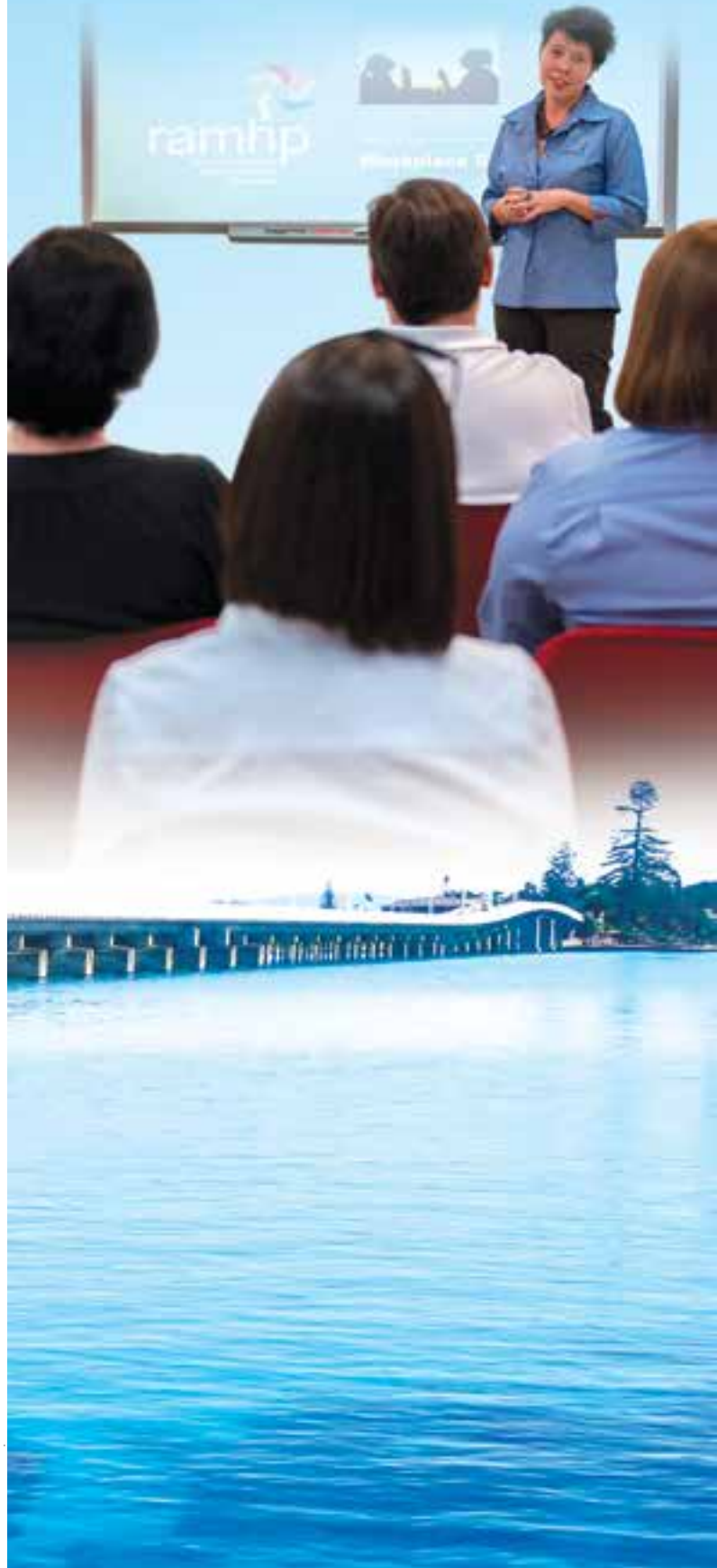
In recent years, several efforts have been made to implement a form of suicide awareness and gatekeeper training tailored for Aboriginal and Torres Strait Islander health workers and communities.

The **CRRMH** is currently delivering and evaluating the "We-Yarn" program which is co-delivered by an Aboriginal man with lived experience of suicidality and a non-Indigenous facilitator. We are working towards training other Aboriginal facilitators so that in the future the program can we delivered more widely. We have learned that:

- Permission to provide the program must be given by elders and by Aboriginal health service providers
- Aboriginal service providers should be trained first, and then participate in yarning with the wider community
- Aboriginal service providers and communities want to talk about suicide and how to prevent it
- Program delivery must be flexible and allow plenty of time for the telling of cultural stories and stories of the experience of suicidality
- Participants see the restoration of connections to lore, land, family and community as key to the prevention of Aboriginal suicide.

A national "Gatekeeper Training Initiative" would be helpful to identify the settings in which such training should be rolled out routinely, and to provide incentives to workplaces to ensure that identified "gatekeepers" are well trained and able to reach out to those colleagues who may be experiencing suicidality and support them to access appropriate health and support services.

1. **Identifying suicidality in the community – what could work?**

   n. A national "Gatekeeper Training Initiative" should be rolled out across rural and remote Australia to enable those in "frontline" or "first responder" positions to provide assistance to people who experience suicidality

   o. Provide encouragement to employers to provide regular gatekeeper training programs in the workplace

Other support for those who are experiencing suicidality

It is often the case that the development of suicidal thinking and the formulation of plans take place in private and is not disclosed to others, even if they ask. This is perhaps even more likely in rural and remote areas where the risk of social isolation may be greater than in capital cities and larger rural towns.

Consideration should be given to a carefully planned public health awareness campaign targeted at rural and remote areas. One goal of such a campaign might be to encourage those in the community who are having thoughts and plans of suicide or those who have made a suicide attempt to reach out for health and social support.

To inform this campaign, research needs to be undertaken into people's knowledge about the availability of crisis support services and their ability to identify the best crisis services for different groups in the community. Research is also needed to determine how those who experience suicidality may be motivated to act to reduce their own risk of death by suicide.

At the local government level, an assessment of locations that are commonly chosen for suicide should be undertaken and local plans devised to minimise the likelihood of further suicide attempts at these sites could be undertaken.

1. **Other support for those who experience suicidality – what could work?**

   p. Design and roll-out a rural public health campaign that encourages people who experience suicidality to use health and social support services

   q. Identify ways in which access to the means or locations of suicide in rural and remote areas can be restricted
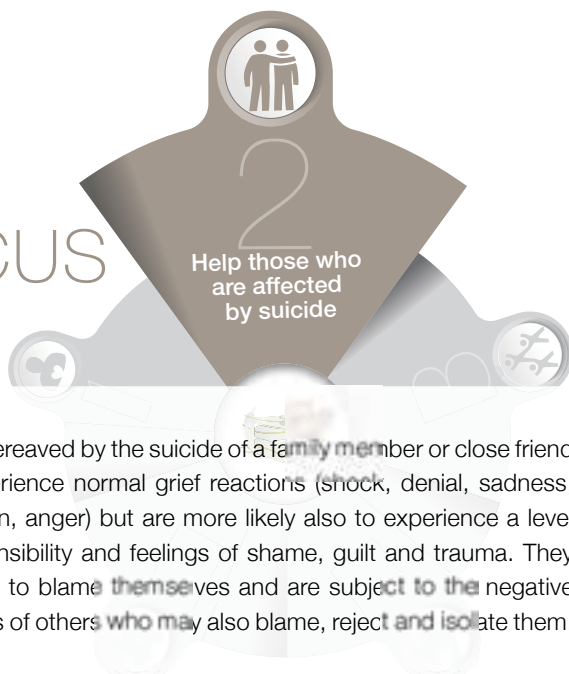
Those bereaved by the suicide of a family member or close friend will experience normal grief reactions (shock, denial, sadness, confusion, anger) but are more likely also to experience a level of responsibility and feelings of shame, guilt and trauma. They are likely to blame themselves and are subject to the negative reactions of others who may also blame, reject and isolate them.

A particularly acute impact will be experienced by those bereaved who have shared the burden, often over many years, of supporting a person with serious mental illness and those who have played an active role in trying to prevent a person who experiences suicidality from dying (being on "suicide watch").

The risk of negative impact is higher for those who are close to the deceased person: their life partner and children; their siblings; those in their friendship groups; and those at the same workplace or who share an occupational association. In smaller rural areas, the knowledge of a recent suicide spreads rapidly throughout the community and can often cause a great deal of concern. The person's GP and others who may have been providing support are also at risk of a higher negative impact.

What we heard at the Rural Suicide Prevention Forum

"So rural communities are very connected and very proud. We thrive on the sense of community and love knowing that we can count on each other to pull together. That same connectedness means that a crisis or disaster has an impact on the entire community. Everybody knows everybody and we are all touched by a tragedy."

Sonia O'Keefe (NSW Farmers Association)

Research from American and Australian researchers has shed light on how many people are affected when they find out about the suicide death of a person they know [19]. Forty-eight percent of their sample reported that at some time in their life they have known someone who had died by suicide.

On average, the respondents knew of three separate people who had died by suicide, while 1% had known more than ten. Those who had been exposed to suicide were much more likely to experience depression, anxiety, suicide ideation or post-traumatic

stress disorder (PTSD) compared to those who reported that they had not known anyone who had died by suicide.

While policy makers across the world recommend the provision of support for those bereaved by suicide, it is difficult to make specific recommendations due to the lack of epidemiological and intervention research that has examined who needs support, the type of support needed, and for how long that support is needed.

Nevertheless, there is enough research and practice-based evidence to suggest several courses of action.

A recent qualitative study of people bereaved by suicide identified three main themes:

- The need for acknowledgement of the loss and the life of the deceased;
- The role of stigma following the loss; and
- The need for proactive provision of direction and support during the grief journey [20].

The authors have made several recommendations about how a GP might provide support to bereaved family members. How GPs can provide other support should form the basis of suicide prevention training targeting GPs and medical students.

Recommendations for the GP coping with those bereaved by suicide [from 19]

- Understand the grief process in suicide and be aware of the effects of stigma
- Use the term 'died by suicide' not 'committed suicide'
- Be aware of a potential shift in family dynamics following loss by suicide
- Be vigilant about assessing the mental health of those bereaved. Tag the notes of family members when a suicide occurs. Note the anniversary and birthday of the deceased and be aware that these times may precipitate mental ill-health in the survivors
- Always acknowledge the loss and mention the deceased person by name where possible
- Make yourself aware of voluntary and professional support services in your local area
- Bear the complexity of suicide-grief in mind when scheduling visits to the surgery: allow time, accommodate patients who do not wish to wait in the waiting room, consider house calls where necessary
- Consider developing a practice policy to train ancillary staff to facilitate these visits
- When considering medication, try to ascertain if this is something the patient wants and, where appropriate, make sure the patient is educated about their medication and the potential delayed onset of effect
- Be proactive: be the first to contact the bereaved
- Be aware of your own limitations and emotional barriers and, if you feel unable to provide optimal care to the suicide-bereaved, suggest a suitable colleague as an alternative

Apart from their GP, family members may receive help and support from bereavement support services.

Inquiry should be made about the adequacy of bereavement support services in rural and remote areas and strategies developed to address any inadequacy or inequity in the provision of these services.

Staff and volunteers of these services should be trained to understand the particular nature of grief after suicide and to provide appropriate support to those bereaved by suicide.

All people bereaved by suicide should be provided with information about the likely impact on them and the range of bereavement support and other counselling services available in the local community and by telephone or online. Standardised health information should be developed which can then be tailored by PHNs and local health authorities to include locally relevant information.

Rural schools should be provided with information, advice and practical assistance to support those affected by suicide in their school community. Similarly, access to information, advice and assistance should be made available to rural workplaces, possibly through work safety authorities in states and territories, especially when a suicide happens at work.

Ordinary citizens are probably best able to reach out to and provide support to those bereaved by suicide. It is difficult to know how to start a conversation and so there is a need to provide quality information and advice on how conversations about suicide can be held in a safe and helpful way. In NSW, a set of resources called "Conversations Matter" has been developed which could be adapted, evaluated and disseminated across rural and remote areas, perhaps through a partnership with local government authorities.

CONVERSATIONS MATTER
resources for discussing suicide

A range of practical resources relevant for individuals, families, community groups, workplaces and educational settings are available from the Conversations Matter website: www.conversationsmatter.com.au

Resources include:

- Talking to someone who is thinking about suicide
- Talking to those bereaved by suicide
- Telling a child about a suicide
- Having a safe group discussion about suicide
- Managing community discussions about a local suicide

The public health awareness campaign recommended previously should include information and encouragement for rural people to reach out to those friends, neighbours, work colleagues and others who have lost someone to suicide or those bereaved by suicide. Widespread dissemination of the "Conversations Matter" resources to rural and remote areas is recommended.
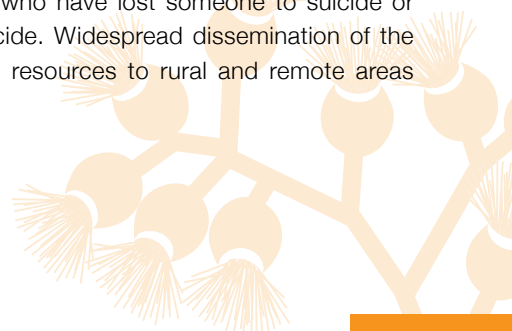
Reporting of suicide in the media

It is apparent that people in rural and remote areas consume more media than people in larger cities. They have local news provided by the radio, television and in the local newspapers, as well as the media they receive from state and national news outlets and social media. Journalists working for rural media are usually residents in the rural community, and are often reluctant to report about suicides that occur in the local community out of sensitivity to those who have experienced the loss. They may even be a friend or acquaintance of the deceased person. Nevertheless, locals are able to read, listen or watch the news published in the state capitals, as well as be exposed to a variety of social media channels. Due to this, local contexts are often not reported on, perhaps leaving a false picture of the community in which the person who died by suicide lived.

Rural media need support to develop safe and helpful ways of discussing the issue of suicide in their newspapers, radio, television programs and online channels.

What we heard at the Rural Suicide Prevention Forum

"Given that suicide is a preventable cause of death, saying NOTHING about how to prevent it makes no sense.

If you are worried that someone may be at risk of suicide, saying NOTHING makes no sense.

If you know someone who has experienced a loss (because of suicide) saying NOTHING makes no sense.

Given suicide is an issue that affects everyone, having a media that reports NOTHING makes no sense.

But, saying whatever we like, whenever we like, with little concern about the impacts our words may have, is also inappropriate."

Jaelea Skehan (Everymind)

2. **Help people affected by suicide – what could work?**
   a. Provide outreach and ongoing support to people bereaved by suicide
   b. Publicise the ways in which GPs can support those patients
   c. Undertake an audit of bereavement support services in rural and remote areas of Australia
   d. Educate staff and volunteers of bereavement support services in remote areas of Australia to ensure support provided to those bereaved by suicide is in line with current best practice guidelines [21] [22]
   e. Provide suicide bereavement support information, tailored for rural and remote areas
   f. Provide specific suicide bereavement support for schools and workplaces, tailored for rural and remote areas
   g. Disseminate the "Conversations Matter" resources across rural and remote areas to assist ordinary citizens to have helpful conversations with, and to support, those bereaved by suicide, tailored to rural and remote contexts
   h. Ensure journalists employed by rural media have opportunities to receive training and other support to develop safe and helpful ways of discussing suicide in newspapers, radio, television programs and online
   i. Increase support for people bereaved by suicide in a suicide awareness campaign for rural areas

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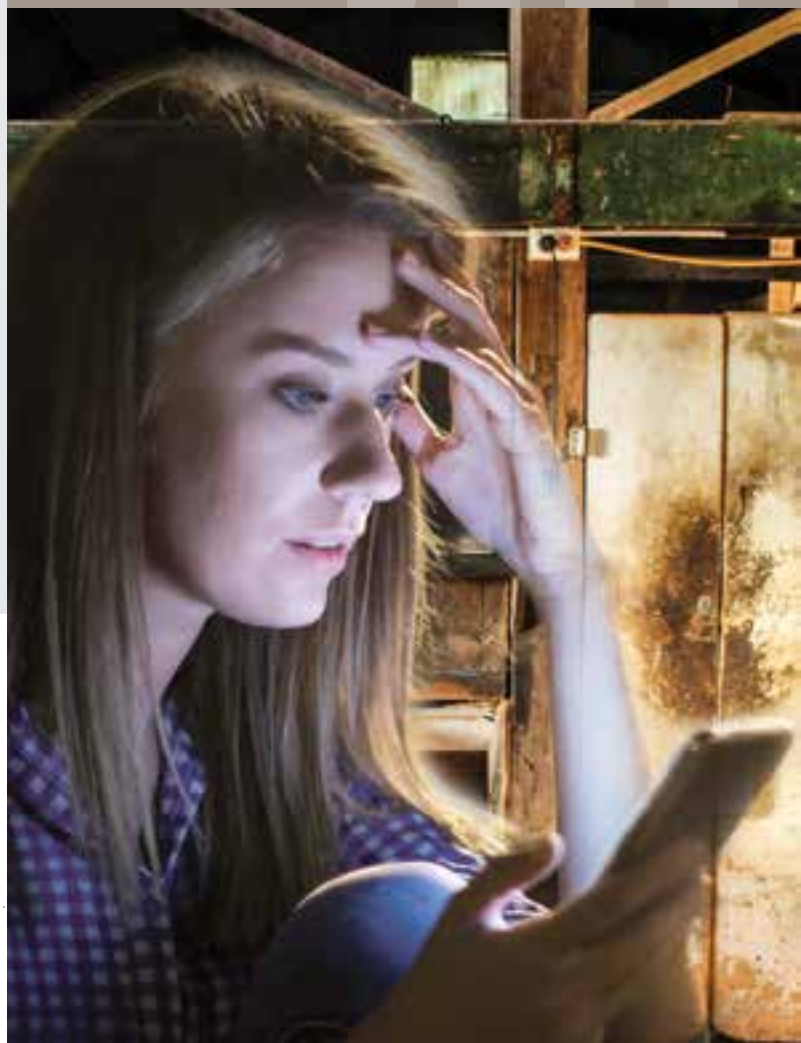
3 Provide support to vulnerable groups

Counselling and social welfare support services must be adequate

Government and non-government services for vulnerable and disadvantaged people in rural and remote areas need to be as high-quality and accessible as those provided in capital cities and large regional centres. These services include income support, social housing, home and community care, domestic violence, disability, and relationship counselling services.

The staff of these services are well placed to identify and provide low-level support to those whose circumstances may increase their likelihood of experiencing loneliness, mental health problems and risk of suicide.

One service that is ubiquitous across rural and remote Australia is Centrelink and, in addition to providing income support, it also provides access to social workers and psychologists. To ensure a minimum level of expertise is available in rural and remote areas, Centrelink social workers and psychologists should receive training to enable them to manage referrals for clients with mental illness and those considered by other staff to be at risk of suicide or self-harm. Centrelink should actively promote the use of their social work and psychology services.

Similarly, all regional and rural offices of government provided and government-funded social welfare services should have at least one staff member trained in the Applied Suicide Intervention Support Skills (ASIST) 2-day training course.

Where social support services are provided by not-for-profit, non-government organisations funded by the Commonwealth or state governments, contracts should require providers to have plans for equitable and adequate provision of services in rural and remote areas. Each rural service provider should have a clear policy on how any concern about suicide in a client should be managed.

3. **Counselling and social welfare support services – what could work?**
   a. Ensure all Centrelink social workers and psychologists are adequately trained to provide support to clients who may be vulnerable
   b. Provide mental health and suicide prevention training to social support agencies provided by government or government-funded agencies in rural areas

Supporting vulnerable people in the community

While certain people may be more pre-disposed to thinking about suicide, it is the stress associated with their present circumstances that exacerbates that condition and leads to thoughts and intentions to harm themselves.

> Ordinary citizens may have the most important role to play by being willing to lend a helping hand to those who are doing it tough.

While it is not always possible to know that a person is experiencing hard times, it is possible to observe their behaviour and listen to their words and then to show concern, enquire about the person's wellbeing and offer to stand by them until the situation improves.

Common signs that someone is "doing it tough" include:

- Harmful alcohol or other drug use
- Reckless behaviour which is out of the ordinary
- Withdrawal from social situations
- Neglect of personal care.

Social isolation and social exclusion are important barriers to full participation in rural life. Rural communities (perhaps with leadership from local government) should be encouraged (and resourced) to develop positive strategies to reduce loneliness and promote the social inclusion of all marginalised groups within their local communities.

A public awareness campaign throughout rural and remote Australia should be designed to reduce the stigma associated with mental illness and suicide, using mental health and social support services. A partnership between rurally located health agencies and local media (print, radio, television and online) should be considered to increase the effectiveness of such a campaign. As a part of this campaign, schools and workplaces are important targets for assistance to understand more about mental illness and suicide.

3. **Provide support to vulnerable groups in the community – what could work?**
   c. Increase social inclusion in rural and remote Australia and reduce the marginalisation of vulnerable groups
   d. Conduct a public health campaign in rural and remote areas to reduce social isolation and stigma associated with mental illness and suicide

FOCUS

4

Build protective factors in children and young people

Many of the known risk factors for mental illness and suicide (in both younger and older age groups) have their origin in childhood. Addressing the conditions that children experience in childhood and adolescence is an important longer-term strategy for prevention.

Childhood risk factors include: early experience of loss (including family disintegration); exposure to domestic and other types of violence; low family income; unstable housing; and poor physical and mental health. Children who experience chronic illness are at higher risk of anxiety and depression [23].

Suicide prevention for these groups can focus on three main strategies:

1. Reduce the prevalence of risk factors and adverse life events in childhood;

2. Provide support to children and parents when they display behavioural and emotional problems, experience early learning difficulties, or are exposed to trauma and other adverse life events; and

3. Increase the resilience of children and young people.

Reduce the occurrence of risk factors and adverse life events in childhood

The experience of risk factors and adverse events can begin soon after conception. The overall health of children is further dependent on the mother's health during pregnancy.

Some childhood accidents can be avoided, and while the development of chronic illnesses may not be entirely avoidable, it is possible to reduce the likelihood in many cases. The higher prevalence of risk factors related to child and maternal health and the development of chronic illness in rural and remote areas should not be ignored.

Those responsible for planning, evaluating and implementing public health programs should consider how they may help to reduce rural suicide. Studies which aim to evaluate the effectiveness of public health measures may also consider including measures of childhood mental health as key outcome measures.

A sense of being safe is essential for good health and wellbeing. Exposure to conflict and violence in the family, neighbourhood and at school, is an important risk factor for children. The work done by police, local councils, and schools is very important to the longer-term prevention of suicide.

A child who experiences a breakdown in parental relationships is also at higher risk for suicidality in their teenage years and throughout life. It is important that people in rural and remote Australia have the same access to family relationship counselling as anyone else in Australia.

4. **Reduce the occurrence of risk factors and adverse life events in childhood - what could be done?**
   a. Implement and evaluate programs to reduce family and neighbourhood violence, the use of tobacco, alcohol and other drugs during pregnancy and in early childhood to improve child health, reduce the likelihood of chronic illness and ensure their relevance to rural and remote settings
   b. Implement rurally relevant and tested programs to improve maternal and child health
   c. Ensure the adequacy and accessibility of family relationship counselling services to reduce family breakdown

Provide support to vulnerable children and their families

An Australian study [23] which followed children from seven to 36 months old found that up to 14% of children exhibited behavioural problems by the end of the study.

The longer-term consequences of these early problems include:

- Learning difficulties
- Poorer peer relationships
- School dropout
- Substance abuse
- Poor vocational outcomes
- Alcohol abuse; and
- Suicide.

To avoid these difficulties, parents and children need access to specialist education and health expertise.

An enquiry should be made into the adequacy of services provided to children and families who live in rural and remote Australia, and to devise and provide funding for strategies to ensure equal access and quality. The beneficial effects of home visits to the mothers and babies of low-income families have long been known. This enquiry should examine how this service could be provided in rural and remote areas.

Similarly, there is evidence that providing mentorship by supportive, stable and mature adults is effective in helping vulnerable young people. This strategy could be relatively easy and inexpensive to implement in rural areas. Such a program should be well-designed and evaluated before implementation at the local level.

Children who experience traumatic events (whether natural or man-made) may experience medium to long term anxiety. While it is normal for such events to lead to a short period of increased alertness and anxiety, these effects tend to diminish over time (four to six weeks). Prolonged anxious behaviour should be identified and psychological and social support provided.

Families and schools need to be provided with access to high-quality health information after their children have been exposed to trauma. Schools may need additional support to recognise the signs of ongoing anxiety and children need to be given access to expert psychological and medical advice.

4. **Provide support to vulnerable children and families - What could be done?**
   d. Provide assistance to rural children (and their families) who exhibit behavioural and emotional problems, or learning difficulties through individual, family-focused and school-based programs
   e. Provide early-childhood home visits to provide education by trained staff to rural low-income expectant and new mothers
   f. Introduce mentoring programs to connect vulnerable young people and supportive, stable and mature adults
   g. Provide psychological and social support for children who experience traumatic events and show signs of being anxious

It is recognised that many of the above points may already exist in some form in rural areas. The point here is that all rural communities should have equitable access to such important preventative support services
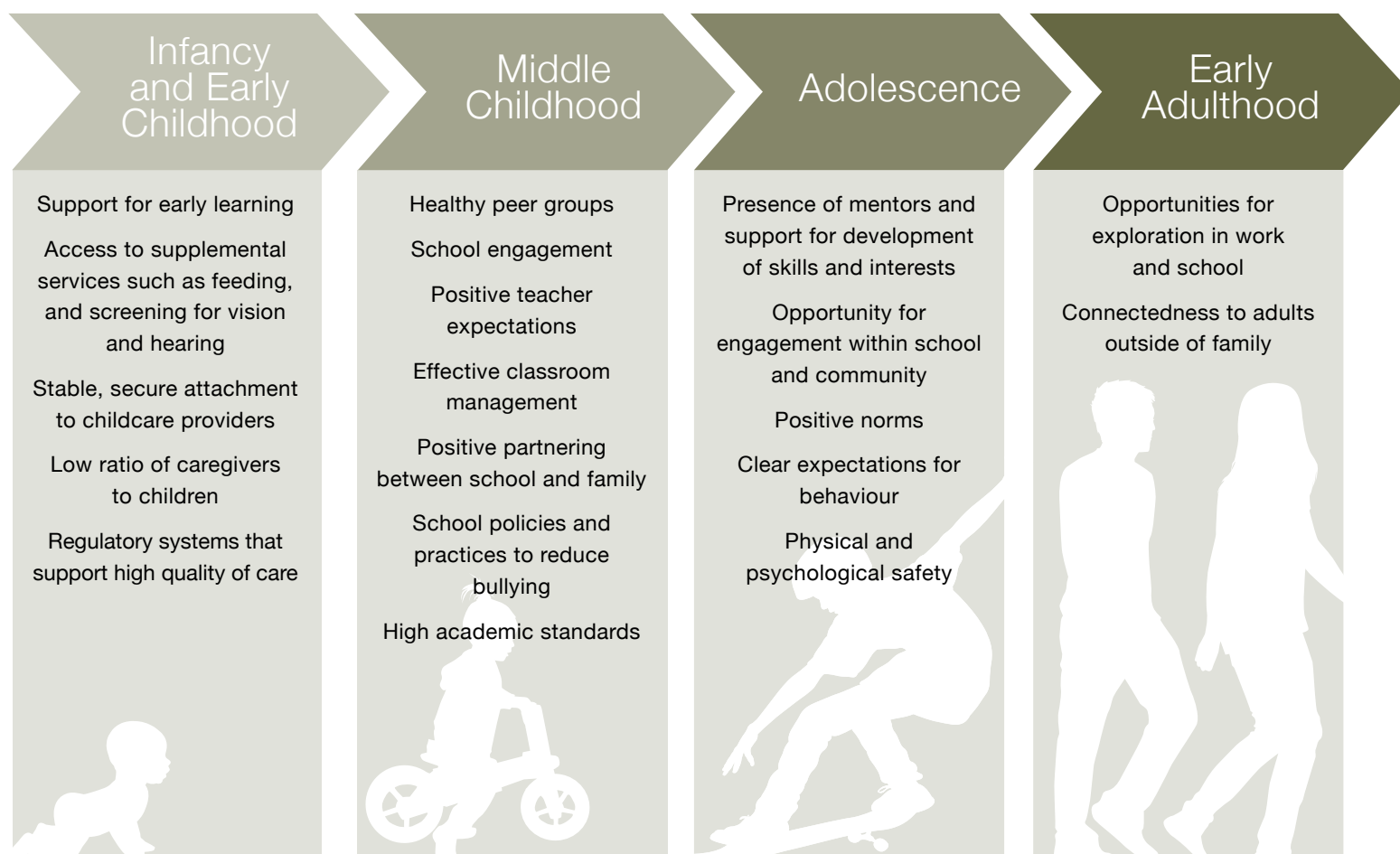
Increase the resilience of children and young people

"Closing the gate after the horse has bolted" is a well-known rural metaphor, indicating the foolishness of doing something to prevent problems after they have already happened. Building the resilience of children and young people provides them with protection against experiencing mental health problems in later life should they experience serious problems as a result of traumatic events.

Fortunately, much valuable work has been done to identify the link between individual, family and environmental factors that are associated with the prevention of mental health problems later in life [24] and interventions have been trialled to address many of them.

Figure 11: Environmental factors associated with the prevention of mental, emotional and behavioural disorders in young people [24]

Infancy and Early Childhood	Middle Childhood	Adolescence	Early Adulthood
Support for early learning	Healthy peer groups	Presence of mentors and support for development of skills and interests	Opportunities for exploration in work and school
Access to supplemental services such as feeding, and screening for vision and hearing	School engagement	Opportunity for engagement within school and community	Connectedness to adults outside of family
Stable, secure attachment to childcare providers	Positive teacher expectations	Positive norms	
Low ratio of caregivers to children	Effective classroom management	Clear expectations for behaviour	
Regulatory systems that support high quality of care	Positive partnering between school and family	Physical and psychological safety	
	School policies and practices to reduce bullying		
	High academic standards		

4. **Increase the resilience of children and young people - what could be done?**
   h. Develop a national initiative for promoting the resilience of children and young people through early childhood, in school, university and vocational settings
   i. Design specific strategies for and assign sufficient resources to support full implementation in rural and remote areas

Australia has already made considerable progress in developing healthy and safe schools. Australian and state governments should ensure that their early childhood and education policies contain measures to create mentally healthy environments. Adequate professional development and other support should be available for early childhood centres and schools to implement health promotion programs in rural and remote schools. Evidence from the evaluation of a range of health and mental health promotion initiatives indicates that a combination of strategies should be implemented concurrently, including what is taught, how it is taught and how the overall school environment and ethos is configured to support the desired changes.

FOCUS 5

Build heathy and resilient people and communities
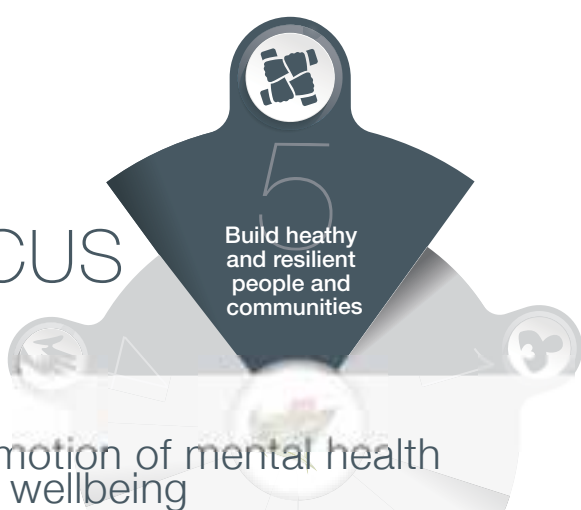
Promotion of mental health and wellbeing

A focus on the promotion of good mental health and wellbeing was once a cornerstone of national mental health and suicide prevention plans in Australia and remains so in many overseas countries. While the Fifth National Mental Health Plan refers to health promotion, it does not suggest any concrete actions or assign responsibility for this component of suicide prevention.

The World Health Organisation [25] and the Centres for Disease Control and Prevention (CDC) [6] recommend a focus on health promotion as an important part of national suicide prevention plans.

Although much more should be done to build the evidence base for effective interventions, the **CRRMH** believes that a National Suicide Prevention Strategy that does not contain a focus on building better mental health and wellbeing is short-sighted and pessimistic.

The **CRRMH** advocates for Australia to take a long-term view on the prevention of suicide by reinstating an emphasis on building individual and community strengths so as to bring about a continuous decline in suicide rates.

Two things need to be done:

1 Build mental health and well-being in rural communities

2 Build the resilience of rural communities

Build mental health and wellbeing in rural communities

In recent years, many organisations have seen the value of creating supportive workplace environments that promote the mental health and wellbeing of staff and customers and there are a great many resources available to assist organisations that wish to adopt a mental health promotion strategy. Indeed, several organisations have been motivated to develop and adopt policies and strategies to ensure a mentally safe and healthy workplace. This trend is due to two main factors: workplaces have come to recognise that poor mental health contributes to accidents at work and to greater absenteeism and presenteeism[4].

In Western Australia, the government has funded the Act-Belong-Commit campaign which has been adopted by local government authorities, workplaces and schools. The campaign was developed by researchers at Curtin University and was informed by community consultation and a review of the literature [26]. The campaign has been carefully evaluated and adopted in numerous local communities across Australia.

act belong commit

Keeping active, having a sense of belonging and having purpose in life are all good for our mental health.

[4] Presenteeism refers to the loss in time at work by people who attend work but whose productivity is reduced due to their mental health problems or by worrying about the illness of a family member.

The campaign seeks to achieve twin objectives: to inform and motivate individuals to adopt three behaviours that will improve mental health; and to encourage local schools, workplaces, organisations and local councils to provide support for individual behaviour change by providing coordinated opportunities for people to "Act-Belong-Commit" together.

In response to an increase in suicide rates in some rural communities, local councils have worked with other organisations and community members to develop ways in which community wellbeing can be improved as a means of preventing further suicides. One example of this is in the Clarence Valley Council area, where a wellbeing collaborative has been established. The group gave themselves the title "Our Healthy Clarence" to demonstrate their intention to build health in response to suicide and to be optimistic of better times ahead.

Our Healthy Clarence

During 2016-17, an extraordinary coordinated community health and community services effort was created in the Clarence Valley to address a higher-than-state-average rate of suicide in the Grafton, Yamba and Maclean region of NSW since early 2015. In response, a four-phase process has been implemented:

1. Community meetings to discuss the issue;
2. Community interviews to identify risk and protective factors and existing mental health and wellbeing strategies;
3. Workshops to commence development of local strategies; and
4. The formation of the" Our Healthy Clarence" Steering Committee to lead the development and implementation of the 2016 – 2018 plan for improving mental health and wellbeing in the Clarence Valley.

   The Plan has been designed collaboratively and belongs to everybody in the community. No one organisation has jurisdiction over it.

5. Build mental health and wellbeing in rural communities – what can be done?
   a. Provide incentives for workplaces and other organisations to adopt policies and programs to promote the mental health and wellbeing of employees and members
   b. Promote the adoption of mental health promotion campaigns (such as Act-Belong-Commit) at the local community level with leadership by local government authorities which already play a very important role in providing and improving the amenity that is needed for individuals to adopt mentally healthy behaviours

Build rural resilience

Resilience is the capacity to adapt successfully to change and to the onset of adverse circumstances or trauma.

Individual resilience is developed over a person's lifetime and depends on a combination of personal strengths, previous experiences, and support derived from family, neighbours and community. For people living in rural areas, individual resilience is improved by being connected to robust and supportive rural communities.

A paper on rural resilience in Eastern Europe [27] describes a model of rural resilience in terms of the quality of and balance between its social, economic and environmental capital, which is referred to by the author as the 'multi-functionality' of rural communities (see Figure 12).

When one aspect of rural community functionality is threatened, the community's ability to adapt to adverse circumstances depends on the quality of the other forms of capital. In times of adverse economic conditions (such as reduced demand or poor commodity prices), or of environmental problems (such as drought or bushfire), communities which have invested in building strong social capital are more able to endure and adapt than those without these strengths.

Figure 12: Factors that build resilient rural communities [adapted from 27]
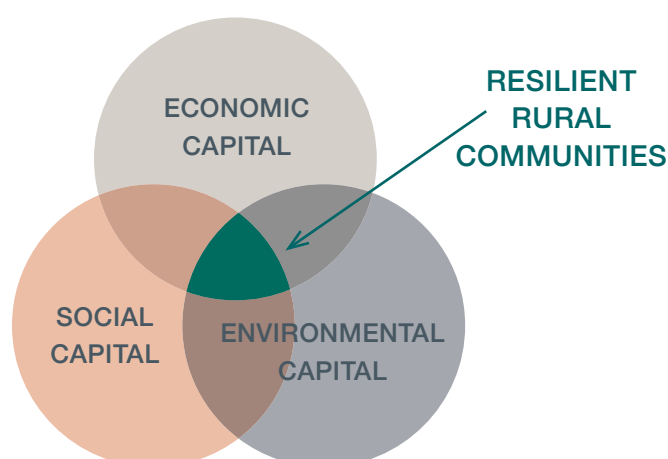
We believe that it is possible to use a range of indicators to identify rural communities which might be vulnerable and to develop plans to restore the capability of such communities to endure current difficulties and to adapt to future change.

Muswellbrook Healthy and Well

The economy of Muswellbrook, in the Upper Hunter region of NSW, has been dominated for many decades by open-cut mining, which has brought many benefits to the community. However, this industry has caused a great deal of environmental damage which will require considerable remediation to return the countryside to its original condition when it mainly supported agriculture. Now the local council anticipates that when the mines and Liddell Power Station close, the economy and social fabric of the shire will be threatened. A process of planning for the future wellbeing of Muswellbrook has commenced with leadership from the Shire Council and other stakeholders taking a Collective Impact Approach to ensuring a healthy future.

The responsibility for implementing a strategy to build rural resilience lies with a very broad range of stakeholders including state government departments of planning and infrastructure, transport and environment. Regional planning bodies and local councils, local business organisations and community members should also be involved.

Identifying those communities which need most support in building their resilience (whether these be at the LGA level or small town level) would be an effective first step.

Building strong multi-functional rural communities is an important investment to ensure that such communities can support the vulnerable in times of adversity and those who may experience suicidality.

5. Build healthy and resilient rural communities - what could be done?
   c. Compile indicators of the social, environmental and economic capital of rural communities to identify pilot sites for the implementation of strategies to improve the resilience of communities whose social, environmental or economic capital is weak
   d. Monitor progress in the resilience of rural communities over time

How should we go about preventing rural suicide?

This section outlines some general principles that the **CRRMH** considers should be used to guide future work in preventing rural suicide.

Approaches to the prevention of rural suicide should be aspirational

Suicide is a stubborn problem and if we knew the answers we would be seeing lower suicide rates. Clearly the way we currently think about and respond to the problem is not working in regional, rural and remote Australia.

Until now the public response to the problem has understood suicide as a health or mental health issue. Most of the national and international reports and plans have focussed on preventing those who experience suicidality from trying to end their life. Evidence for effective interventions is limited and focusses too strongly on identifying and treating people who experience suicidality.

While helping those at risk of suicide due to their present circumstances is important, it is not a sufficient response, especially if we want to reduce the number of people who experience the distress of suicide well into the future.

Higher rates of suicide in rural and remote Australia, and the current upward trend in rural suicide rates, cannot be accepted.

Two aspirational goals should be set:

1 To reduce the gap in suicide rates between those in rural and remote areas and those in the greater capital city areas; and

2 To reverse the upward trend in annual rural suicide rates.

To achieve these goals, we will need to act immediately to reduce suicides in rural areas and the number of people who experience suicidality in both the short and long term.

Suicide prevention should be addressed using a public health lens

Most of the risk and protective factors for mental illness and suicide also influence other aspects of individual and public health.

For too long, suicide has been viewed only through the lens of mental illness and consequently suicide prevention has been left to health and mental health practitioners.

Increasingly, suicide is recognised as a public health issue and the knowledge and expertise of public health practitioners is now needed to design a comprehensive public health approach to suicide prevention.

Broad public health approaches that address the known risk and protective factors for good health and mental health should be included in any plan for rural suicide prevention.

Rural suicide prevention should include a focus on creating "suicide safe" communities by:

- Planning for the longer-term economic viability and prosperity of rural communities;
- Creating safe environments in the home, the school, the workplace and in the community;
- Creating socially inclusive rural communities that reject discrimination due to race, ethnicity, sexual preference etc., especially of those who live alone or are in more remote geographic locations;
- Increasing the understanding of good mental health and how individuals and communities can increase their overall health and wellbeing; and
- Increasing the understanding of mental illness and suicide.

Regional and local planning should aim to create a balanced rural environment that maximises the social, economic and environmental capital of rural communities. When some rural communities become vulnerable due to changes in social, economic or environmental degradation, assistance should be provided to manage the negative impact on those who continue to live in those communities. Relocation assistance should be considered where the needs of individuals can no longer be met by the local community.

Leadership and planning for rural suicide prevention

Leadership and planning in rural suicide prevention is needed at all levels of government – Commonwealth, State and Territory, regionally and locally. This should extend beyond health and related portfolios, with acknowledgement that healthy resilient communities depend upon social, economic and environmental capital. Medium and longer-term reductions in rural suicide rates will depend on effective policies across health, social, economic, environmental areas as well as due consideration to groups specifically at risk such as males and Indigenous people. Moreover, multiple tiers of government should work cooperatively to create and implement cohesive policies that support rather than compete or obstruct each other.

The role of the Commonwealth

The CRRMH acknowledges the positive gains made in devolving the planning and funding of health, mental health and suicide prevention to the regional level. This decision alone should have a positive impact on the scarcity of health and social support services in rural areas and the development of service models that address local circumstances.

Ideally, overall leadership should be at the prime ministerial level. The CRRMH suggests that the Department of Prime Minister and Cabinet should commence a process in which all relevant portfolios are required to develop a 5-year plan to design and implement policy and funding changes that will contribute to creating robust and prosperous regional and rural communities better equipped to support the wellbeing of their members.

The Commonwealth should strive to provide leadership to the states and regions of Australia to undertake a cross-portfolio approach to planning for longer-term reductions in rural suicide.

The role of the states

What is happening to prevent suicide in capital cities is not working in rural areas of the states of Australia.

Each state should establish its own policy unit to advise the Premier and Cabinet on rural suicide prevention. These units should develop short and longer-term plans for reducing the rate of suicide in rural areas and establish a multi-sector expert panel that includes regional representation to ensure policies and plans are relevant to the diversity of rural communities. This panel should consider that suicide prevention efforts in rural areas need to contextualise approaches that have been successful in more densely-populated areas. This might result in approaches that would not be needed in capital cities.

The role of local councils

Local councils have long held primary responsibility for planning and implementing public health measures. The CRRMH considers local councils as having a vital role to play in achieving the aspirational goals recommended by this paper.

The recently released "South Australian Suicide Prevention Plan 2017-2021" has placed local government responsibilities as one of its main platforms. This leadership is admirable and it is notable that this state has the narrowest gap in suicide rates between its capital city and the rest of the state. Local councils have two broad roles to play: to work in partnership with local communities to plan and implement programs and services that will meet local needs; and to advocate for the wellbeing of their communities.

The suicide prevention strategies recommended in this position paper that are particularly relevant to implementation at a local government level are:

- Adopt policies that promote well-being and prevent suicide and promote these to other businesses and services in the local government area;
- Support positive social connections and inclusiveness of lonely and marginalised groups;
- Identify local gatekeepers and arrange for the provision of gatekeeper training in local communities;
- Lobby for the provision of adequate social support and counselling services; and
- Provide support to, or initiate, local "Suicide Prevention Networks" or "Wellbeing Collaboratives", and ensure that adequate support is provided to participating staff and volunteers.

To facilitate local councils' involvement, state governments should undertake a consultation process to clearly define the particular roles that local government could play, and invest in capability development within local councils to enable them to do this.

The suicide data that are currently available are not adequate for regional and local area planning. While efforts are being made to standardise the collection, and reporting of suicide deaths, even this will not be enough to allow regional planning of suicide prevention strategies. Data difficulties should not hold up the process of taking action to prevent rural suicides.

Efforts should be made at a state level to provide a range of suicide-related indicators annually on a regional and local government level. Such data could include numbers of people presenting at hospital emergency departments, hospital admissions, occasions of service for mental illness and drug and alcohol problems, and reports of domestic and community violence.

The role of local communities

Local communities are best-placed to identify local opportunities for suicide prevention, both in terms of how to help those who might be at risk of experiencing suicidality and how to improve the resilience of their community. A great example of how local communities can be resourceful and achieve good outcomes is the Little River Land Care Group in Western NSW who acted to ensure that farmers in their area were supported during the severe drought that occurred in the last decade.
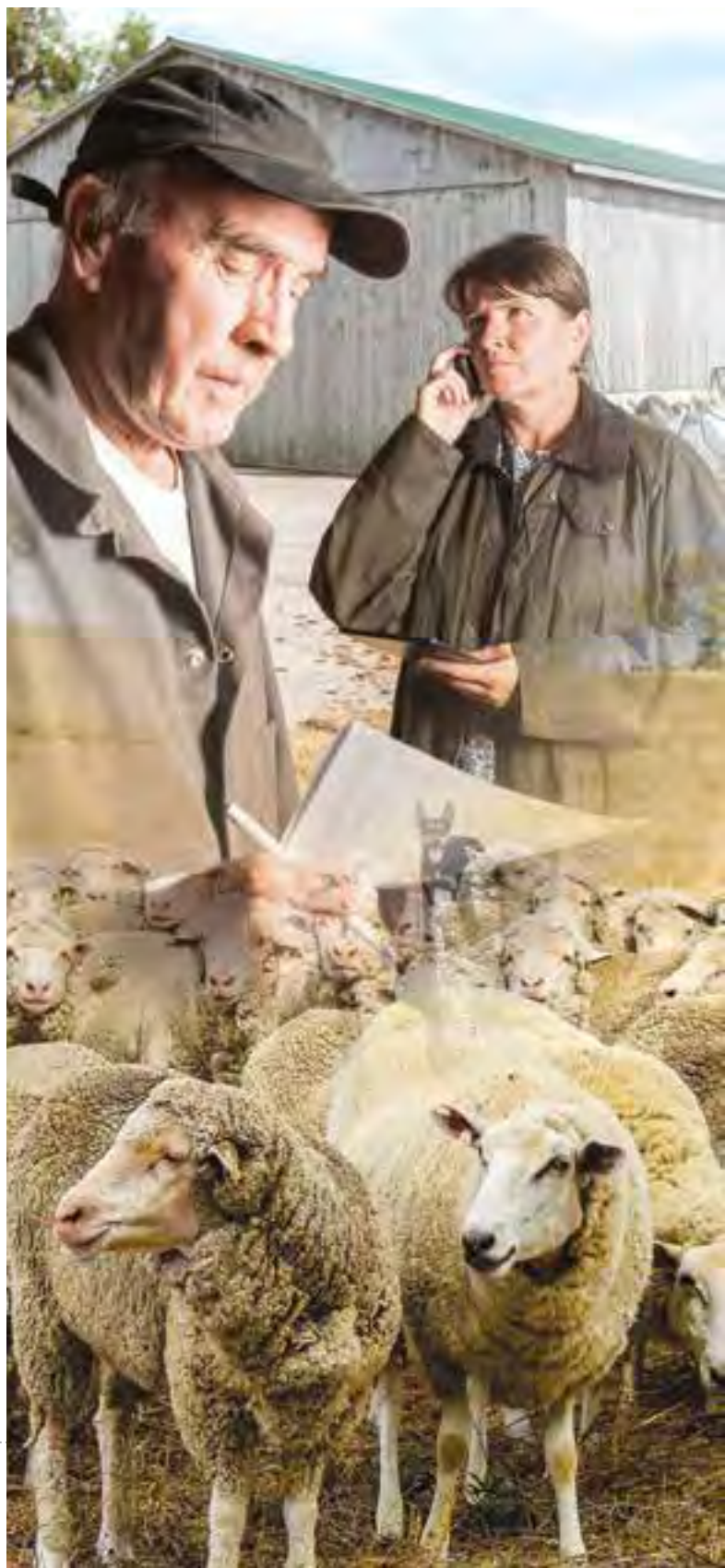
Little River Land Care

"Ask Pip Job what the single biggest accomplishment of the Little River Landcare Group is of the past five years and you might be surprised by the answer. Surprised because it has nothing to do with planting trees, environmental works or anything you might consider 'traditional' Landcare activities.

'For us it's that we haven't lost a single farmer in our catchment to suicide' said Pip, the group's chief executive. By 2007 it was a catchment that had been in drought for three years – and it was beginning to show. Little River's staff found themselves becoming 'accidental counsellors' to members dropping into their office – one of the few remaining community organisations in Yeoval.

For the group, it was a reflection not only of the level of trust they had developed with members but that there was a growing issue around mental health in their region. A string of suicides in the state's west reiterated the severity of the problem – and the need for action.

Pip said it triggered a turning point for the organisation. The group's management committee made a vow it would do everything it could to prevent farmer suicide and raise awareness around mental health."

Story from "farmonline NATIONAL" [28]

National, state and regional suicide prevention plans should actively engage the rural community members to formulate and implement local strategies to prevent suicide and build resilience. Local communities could undertake the following roles:

- Adopt the goal of making their community mentally healthy and undertake local initiatives
- Encourage local organisations (schools, businesses, councils etc.) to adopt policies and programs to ensure they support the mental health and wellbeing of their staff, clients, customers etc.
- Raise awareness of mental illness and suicide to reduce stigma
- Devise local strategies to reduce loneliness and increase social inclusion
- Be alert and recognise those who may be at risk of becoming suicidal
- Be aware of self-help strategies, and online and telephone services that can help people who are experiencing stress in their lives
- Be courageous and reach out to those whom they are concerned about and offer to help them to access appropriate help.

The role of those who have experienced suicide themselves or have been affected by the suicidality of others

Those among us who have had experience of suicidality, have recovered and are no longer at risk, often wish to step up and help others who are having the same experience. Also, those who have provided support to a person who is experiencing suicidality, and those who have been bereaved by suicide can play an important role in the prevention of suicidality in others. These people are said to have a "lived experience of suicide". Should they wish to do so, they need to be connected to one of several organisations which provide training and ongoing support. This is important to avoid any risk that talking about their experience may negatively affect their mental wellbeing. Such organisations need to consider how they can effectively support rural people with a lived experience of suicide. This will enable rural communities to benefit from the roles people with a lived experience can provide.

> People with a lived experience of suicide, who have been given training and have active support, should be given a role in all levels of suicide prevention planning.

Roles that people with lived experience can play include:

- Providing advice on the development of information and resources provided to those who are currently experiencing suicidality, those who are providing them with support, and those who have been bereaved by suicide; and
- Participating in efforts to raise awareness of suicide and to break down stigma surrounding the experience of seeking help for suicidality.

Leadership and planning for Aboriginal suicide prevention

Addressing the shocking higher rates of suicide in Aboriginal and Torres Strait Islander communities is a critical priority for any plan that aims to reduce rural suicide.

The CRRMH urges the Commonwealth and State Governments to give urgent attention to the implementation of the Aboriginal and Torres Strait Islander Suicide Prevention Strategy (2013).

The CRRMH also notes the excellent work of the Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project (ATSISPEP) [9]. A critical recommendation of this report stresses the need for leadership of suicide prevention by Aboriginal and Torres Strait Islander people.

A common success factor in community-based interventions or responses to Indigenous suicide is their development and implementation through Indigenous leadership and in partnership with Indigenous communities.

All Indigenous suicide prevention activity should include community-specific and community-led upstream programs focused on healing and strengthening social and emotional wellbeing, cultural renewal, and improving the social determinants of health that can otherwise contribute to suicidal behaviours, with an emphasis on trauma informed care [9].

As a first step, the **CRRMH** urges a further investment in consultation with Aboriginal leaders and communities in order to design a national capacity-building strategy to enable this aspiration to be realised.

Further investment by state governments to increase the capacity of Aboriginal and non-Aboriginal health and welfare workers to respond to suicide risk in Aboriginal communities is absolutely essential.

In conclusion

The **CRRMH** pays our respects to those who have died by suicide, and those who have lost loved ones and friends to suicide. We acknowledge those who are currently struggling with suicide and trust that the strategies recommended in this paper will lead to better solutions to keep you safe.

We acknowledge the good work of so many doctors, nurses, and other health practitioners who have provided good care and support to people who have experienced suicidality and to their friends and family. Our recommendations are designed to help you to continue your work in a safer environment.

We acknowledge the bravery of those with a lived experience of suicide who use their experience in the cause of suicide prevention, and the courage and generosity of those who have gone out of their way to assist those in distress because of suicide.

We look forward to being part of the solution to the poorly recognised and unacceptable problem of rural suicide.

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Appendix 1 – Theories of Suicide

Theory 1: The Integrated Motivational-Volitional Model

The first of these, *"The Integrated Motivational-Volitional Model of Suicide"* [29], attempts to explain of how people come to the point where they have a reason to start seeing death as a solution to their current distress and then develop the desire for suicide.

Figure 13: Theory 1 – The Integrated Motivational-Volitional Model of Suicide
Adapted from O'Connor R. (2011) [29]
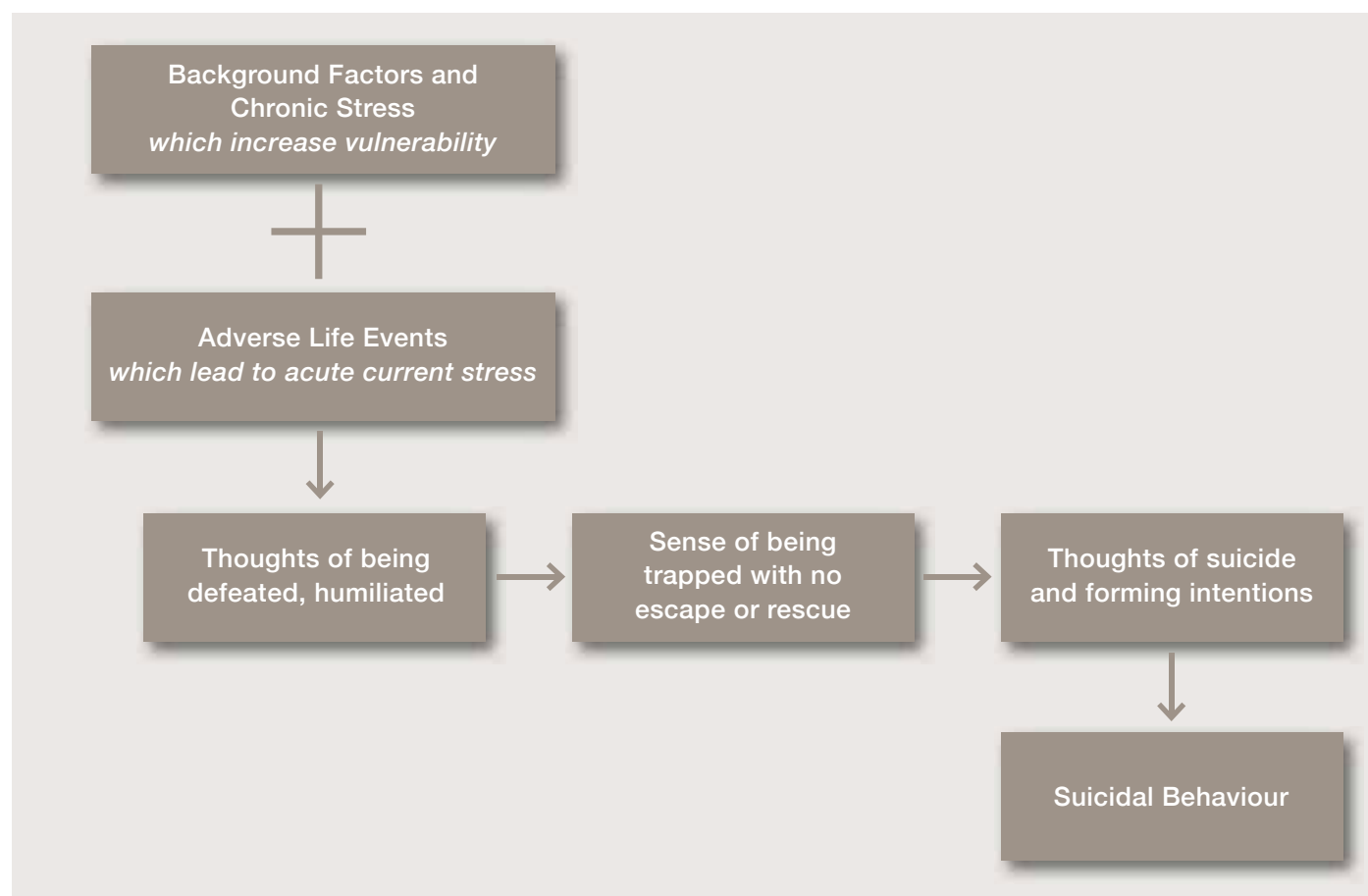
Certain background factors ("risk factors") have been identified that seem to be more common in those who experience suicidality but none of these are so closely linked to later suicide that they are, on their own, likely to lead to suicide. It is thought that these may pre-dispose someone to think about suicide if negative circumstances arise.

In rural areas, social isolation is a particularly potent background factor. While living alone, or being separated by distance from communities and loved ones is very relevant, other marginalised groups, such as people living with disabilities, the elderly, being Aboriginal and, or, being gay, lesbian, bisexual, transgender or intersexual, are more likely to experience social isolation in rural and remote areas.

While many of those who die by suicide have a mental illness, it is not necessary to be mentally ill to experience suicidality and to make a suicide attempt.

The experience of negative life events (such as sudden loss, bullying, loss of employment, relationship failure, accidents, onset of illness or mental illness) can trigger a situation in which a vulnerable person develops a level of motivation and intention and contemplates suicide.

The psychological state of people at risk of suicide is one where they view their current circumstances as overwhelming, they feel defeated and humiliated and unable to solve their problems [30]. They believe they are trapped with no hope of escape, and that there is no one who can rescue them. If over time things do not improve, this may lead to the contemplation of death as a way out of their distress; and, in turn, can lead to thinking about and forming an intention to take their own life . If this escalation is not identified (either by the person or those around him or her), and help is not sought or is not available, the person is then at high risk of making a suicide attempt [29].

Theory 2: The Interpersonal Theory of Suicide

A second theoretical model helps us to understand how it can be that some people are able to override their natural fear of death and the instinct to avoid pain and death, and are able to attempt to take their own life (see Figure 14). The kernel of this "Interpersonal Theory of Suicide" [31] is that, in order for a person to be able to take their own life, they must **desire suicide** <u>and</u> be **capable of causing their own death**. To desire death, the person at risk has reached the point where they have come to hold two firmly-held beliefs: (a) that they are all alone, disconnected from others, with no one to turn to and no one to whom they can give support; and (b) that they are a burden on others, that their death would be worth more than their life to others.

The theory suggests that, although these beliefs are firmly held, they are most likely exaggerated and possibly incorrect. Research shows that, if people who hold these beliefs are identified and receive a range of treatments and supports, they can become more connected and their sense of self-worth can be increased [32].

Figure 14: Theory 2 – Interpersonal Theory of Suicide
Adapted from Van Orden et al. (2010) [31]
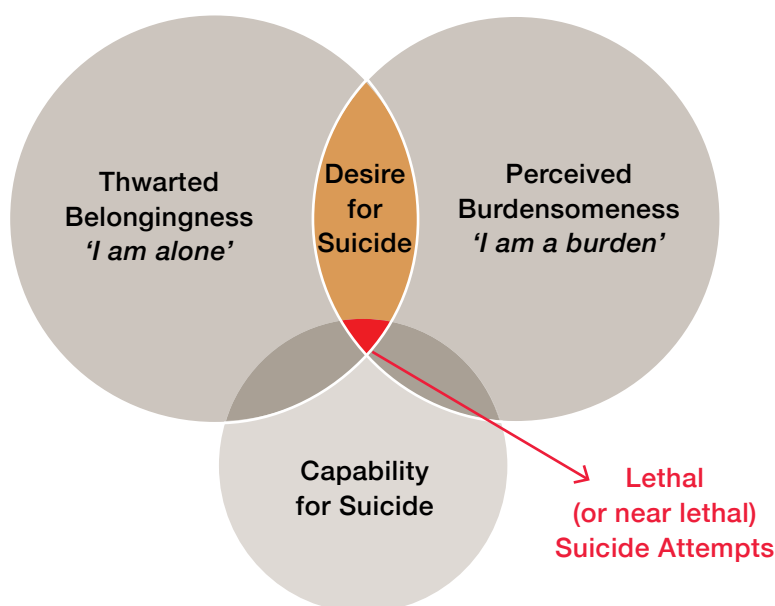
The theory underlines how important it is that, if we are worried about a person, we should ask them whether they are thinking of suicide (no matter how threatening that might sound).

The second element of the theory proposes that certain individuals can become more capable of suicide, either by their natural fearlessness (high risk-taking), or through having developed a familiarity with death and pain (for example being exposed to death through their occupation such as doctors, farmers, stockmen, veterinarians etc.), or through gradually building up the ability to overcome their fears through constantly thinking about and rehearsing how they would end their life.
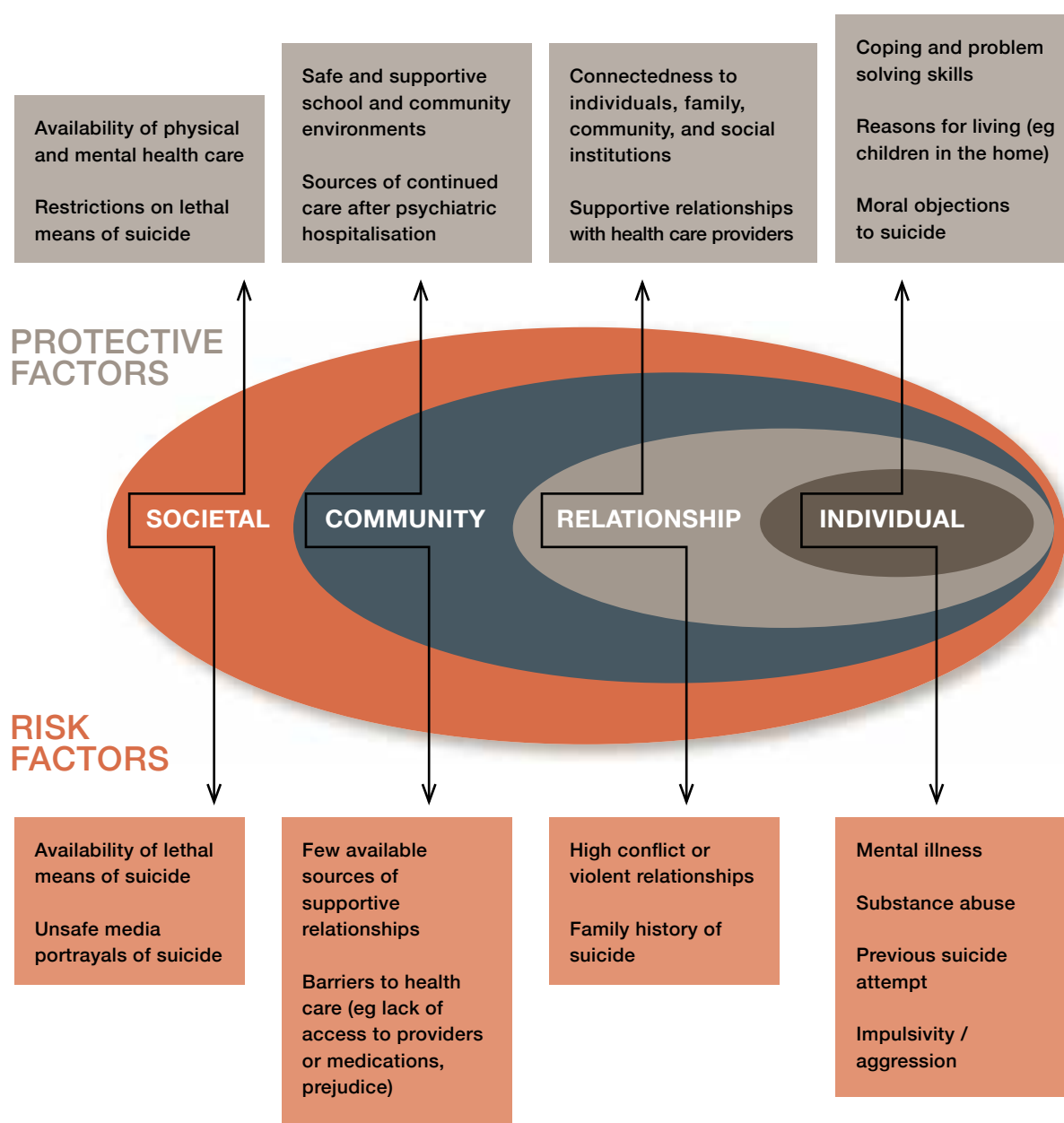
If a person has developed the desire for death and is capable of making a suicide attempt, they are at higher risk of eventually making a lethal or near-lethal attempt on their life. On the other hand, if a person who desires death does not have the capability, or if someone who is more capable of ending their life does not desire death, neither would be likely to make a suicide attempt.

Theory 3: The Ecological Model of Suicide

American research has pointed to the complex factors which may be implicated in a death by suicide and the wide range of agencies and individuals which might be needed for effective suicide prevention.

Figure 15 demonstrates the combination of individual, relationship, community and societal factors which contribute to suicide risk and might need to be addressed in preventing suicides.

Figure 15: Theory 3 – An Ecological Model of Suicide [adapted from 33]

PROTECTIVE FACTORS

Availability of physical and mental health care

Restrictions on lethal means of suicide

Safe and supportive school and community environments

Sources of continued care after psychiatric hospitalisation

Connectedness to individuals, family, community, and social institutions

Supportive relationships with health care providers

Coping and problem solving skills

Reasons for living (eg children in the home)

Moral objections to suicide

SOCIETAL   COMMUNITY   RELATIONSHIP   INDIVIDUAL

RISK FACTORS

Availability of lethal means of suicide

Unsafe media portrayals of suicide

Few available sources of supportive relationships

Barriers to health care (eg lack of access to providers or medications, prejudice)

High conflict or violent relationships

Family history of suicide

Mental illness

Substance abuse

Previous suicide attempt

Impulsivity / aggression

Such public heath approaches imply going beyond trying to identify an individual at imminent risk of suicide and attempting to intervene at that point. It is also necessary to develop interventions that address the needs of vulnerable groups who may become suicidal in the future and to recognise the societal and community factors which may influence suicidality and address them as a public health issue.

GET HELP NOW

If you're concerned about your own or someone else's mental health, you can call Lifeline 13 11 14

If you or someone else is in immediate danger, call 000 or go to your nearest hospital emergency department.

Lifeline
Saving Lives
Crisis Support. Suicide Prevention

Visit www.crrmh.com.au or www.ramhp.com.au for links to services.

Visit www.crrmh.com.au or www.ramhp.com.au for self help resources and downloadable fact sheets.