

# Suicide Prevention

## Policy Position Statement

This policy covers prevention of suicide (including suicide, self-harm, suicidal self-directed violence, suicidal thoughts and behaviours) and support for those at risk of suicide.

**Key messages:** Prevention policies and practices must reflect that there are multiple levels of risk factors for mental health conditions, suicide and self-harm, suicidal thoughts and behaviours including individual, family and relationships, societal and community, and political and economic.

**Key policy positions:**

1. Support and fully resource comprehensive national suicide prevention strategy: Fifth National Mental Health and Suicide Prevention Plan; Vision 2030 for Mental Health and Suicide Prevention; National Children's Mental Health and Wellbeing Strategy; and the National LGBTI Mental Health and Suicide Prevention Strategy; and the National Mental Health Research Strategy.
2. Resource comprehensive national level suicide prevention strategies for Aboriginal and Torres Strait Islander people: National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2017-2023, the 2013 National Aboriginal and Torres Strait Islander Suicide Prevention Strategy
3. Develop specific strategies for high suicide risk groups including children and young people, middle aged men, (LGBTIQ+) people, culturally and linguistically diverse backgrounds (CALD) particularly refugees and asylum seekers, and those living in rural or remote areas.
4. Resource ongoing State and territory level mental health suicide prevention policies and plans.

**Audience:** All PHAA members, government, media

**Responsibility:** PHAA Mental Health Special Interest Group

**Date adopted:** 23 September 2021

## Definitions

This policy adopts the following definitions used by the Centre for Disease Control (US) and used in the *Oxford Handbook of Suicide and Self-Injury*.<sup>1</sup>

<b>Suicide</b>	Death caused by self-directed injurious behaviour with any intent to die as a result of the behaviour.
<b>Self-harm/non-suicidal self-injury</b>	Behaviour that is self-directed and deliberately results in injury or the potential for injury to oneself.
<b>Self-directed violence (SDV)</b> (analogous to self-injurious behaviour), further categorised below	<i>Exclusions: parachuting, gambling, substance abuse, tobacco use or other risk-taking activities. These behaviours may have a high probability of injury or death as an outcome, but the injury or death is usually considered unintentional.</i>
<b>Suicidal self-directed violence (SSDV)</b>	Behaviour that is self-directed and deliberately results in injury or the potential for injury to oneself. There is evidence, whether implicit or explicit, of suicidal intent.
<b>Non-suicidal self-directed violence (NSSDV)</b>	Behaviour that is self-directed and deliberately results in injury or the potential for injury to oneself. There is no evidence whether implicit or explicit, of suicidal intent.
<b>Suicide attempt</b>	A non-fatal self-directed potentially injurious behaviour with any intent to die as a result of the behaviour. The behaviour may or may not result in injury.
<b>Interrupted self-directed violence - by self or other</b>	<p><i>By other:</i> A person takes steps to injure self but is stopped by another person prior to fatal injury. The interruption can occur at any point during the act such as after the initial thought or after onset of behaviour.</p> <p><i>By self</i> (also termed “aborted” suicide behaviour): a person takes steps to injure self but is stopped by self, prior to fatal injury.</p>
<b>Other suicidal behaviour</b> including preparatory acts	Acts or preparation towards making a suicide attempt, but before potential for harm has begun. This can include anything beyond a verbalisation or thought, such as assembling a method or preparing for one’s death by suicide.
<b>Postvention</b>	Support to survivors of suicide attempts and support provided to families and friends bereaved by suicide.

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## Policy position statement

### PHAA affirms the following principles:

1. The risk factors for mental health conditions, suicide and suicidality, are multifactorial, operate at many levels and may overlap, including:
  - **Individual level** (e.g., depression or other mental disorder, harmful use of alcohol and other drugs, job loss, poverty, trauma and grief, sense of hopelessness, chronic illness and disability, family history, history of childhood abuse, previous suicide attempts)
  - **Relationship/family level** (e.g., level of social support, relationship conflict, gendered domestic and family violence and abuse)
  - **Societal and community level** (e.g., social determinants of health, supportive and resilient communities, individual vs collectivist culture, racism, bullying and discrimination, environmental disaster, war and conflict, dislocation and acculturation, access to the means of suicide, conditions in detention and incarceration centres), and
  - **Political and economic factors** (e.g., current economic environment, economic policies, policies on gun control, health and social care policies, human rights policies and conditions, the impact of historical policies negatively impacting upon Aboriginal and Torres Strait Islander people and communities).
2. In recognition of the complexity and interrelatedness of risk factors, suicide prevention policies and practices should be multi-sectoral and interdisciplinary and cover the spectrum from primary to tertiary prevention.
3. Prevention policies need to consider that the rates and causes of suicide and self-harm vary across age, gender, sexuality, race, culture, social conditions and location.
4. Suicide is the result of causative factors and not an illness.
5. Suicide and self-harm, although often associated with a diagnosable mental health condition, are not exclusive to people with mental illness. In many cases a person may not have been in contact with mental health services or have been diagnosed with a mental health condition.
6. Suicide can be both planned and reactive.
7. Suicide prevention should not be argued in the context of assisted suicide/euthanasia.

## PHAA notes the following evidence:

### *The impact of suicide, self-harm and suicidal thoughts and behaviours in Australia*

8. The suicide rate in Australia has increased over the last decade. The standardised suicide death rate in 2019 was 12.9 per 100,000 people compared to 11.9 per 100,000 people in 2016.<sup>2</sup> In Australia about 65,000 people attempt suicide each year and more than 400,000 experience suicidal ideation (thoughts).<sup>3</sup>
9. In 2019, suicide was the leading cause of death among all people 15-49 years of age, and the second leading cause of death among those 50-54 years of age. Suicide accounted for over one third of all deaths in people aged 15-24.<sup>4</sup>
10. Deaths from intentional self-harm occur among men at a rate three times greater than that for women – in 2019, 19.8 deaths per 100,000 people for men, and 6.3 deaths per 100,000 people for women.<sup>4</sup>
11. Suicide is a major cause of premature mortality for Aboriginal and Torres Strait Islander people<sup>5</sup>, with a rate of suicide that is 27.1 per 100,000 - more than twice the Australian national average. Indigenous young people (aged 5-17 years) are particularly vulnerable with the suicide rate almost four times that of non-Indigenous young people for 2015 - 2019.<sup>4</sup>
12. For every death by suicide, there are more than 20 -30 suicide attempts.<sup>3</sup>
13. The rate of hospitalisation for females due to self-harm was 40% higher than for males from 1999–00 to 2011–12.<sup>6</sup>
14. Other population groups at increased risk of suicide and self-harm include children and young people, people from culturally and linguistically diverse backgrounds (CALD) particularly refugees and asylum seekers, people living with a mental health condition,<sup>7</sup> Lesbian Gay Bisexual Transgender Intersex and Queer (LGBTIQ+) people,<sup>8</sup> men living in rural and remote areas,<sup>9</sup> ex-service men,<sup>10</sup> and emergency service workers.<sup>11</sup>, and people experiencing domestic violence.<sup>12</sup>
15. The link between domestic violence, mental health and suicide prevention should be considered within suicide prevention strategies,<sup>12</sup> particularly work on strategies to reduce domestic violence and child abuse, and the need to be responsive to those at highest risk of domestic violence (including women and children).
16. The rise of internet use and especially social media is being increasingly studied in the context of suicide risk and prevention.<sup>13</sup> Risk factors include cyberbullying, cyberharassment and websites with ideas and instructions on how to complete suicide.
17. There is significant impact of suicide on families, child survivors and friends in terms of mental health and social support which should be considered within suicide prevention strategies.<sup>13</sup>

### *Priorities for Policy, Practice and Research*

18. Many of the interventions to prevent and address suicide focus on individuals, families and relationships. Greater focus should be placed on community and societal interventions and risk factors (e.g. family violence and abuse). Also, many of the clinical treatments are tertiary level interventions, and more focus should be placed upon suicide prevention and the underlying causes of suicide.
19. Strengths-based, culturally appropriate and community-led approaches to prevention and interventions, including individual, family and community level programs are a priority. Supportive

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workforce development policies are required, particularly for Aboriginal and Torres Strait Islander workers who may be vulnerable to stress and burnout, especially in resource constrained areas.

20. Given the increased risk of suicide among children and young people, policies and universal prevention programmes should be implemented across schools and education systems.
21. Addressing suicidality (and self-harm) should be a key component of all relevant government policy and programs, relating to the social determinants of suicide, such as social services, employment, housing, and corrections.
22. Appropriately supported discharge (i.e., discharge planning) from hospitals to GPs for people at risk of self-harm and suicide should occur along with support for the zero-suicide model (which includes continuous contact and support with survivors after acute care).<sup>14</sup>
23. Training for mainstream community gatekeepers and first responders, including GPs, particularly for rural, regional and remote areas.
24. Promoting protective factors including the use of public health messaging on social media or websites to promote help seeking and awareness of suicidal risk behaviours to alert family and friends. Regulation and moderation of internet and particularly social media sites remains problematic,<sup>14, 15</sup> despite the establishment of the eSafety Commissioner.
25. Implementing this policy would contribute towards achievement of UN Sustainable Development Goal 3: Good Health and Well-being

### PHAA seeks the following actions:

26. Investment in tailored, multi-sectoral and community level interventions and prevention for populations at high risk of suicide and self-harm to increase resilience and reduce the risk of suicide and suicidal behaviours as a coping strategy, and reduce the need for crisis services.<sup>16</sup> This includes ongoing resourcing of training for health and other workers to promote the identification of those at risk of suicide and self-harm.
27. The expertise of people with a lived experience of attempted suicide or who have been bereaved by suicide should inform the development and implementation of suicide prevention strategies and initiatives. This should be facilitated through genuine and appropriately supported co-design processes.
28. Mental health promotion across the lifespan is necessary to reduce the risk of suicide, including peer support (from those with and without a lived experience), resilience building and specific strategies to reduce racism, stigma, bullying and discrimination.
29. Ensure that information, services and professionals are culturally appropriate and competent including Trauma Informed Practice and Care<sup>17</sup> to increase the likelihood of Aboriginal and Torres Strait Islander people and those from culturally diverse backgrounds to access services.
30. Reduce stigma around help-seeking and provide pathways to health care, for example via community leaders, schools, and online supports.
31. Increase access to timely and appropriate mental health information, services and support through investment and resources to primary mental health services and within schools. This should be a priority for people who have attempted suicide.<sup>16</sup>

32. Investment into peer-led services and community development strategies to engage communities within suicide prevention initiatives.
33. Interventions and support are person-centred and holistic.
34. Recognise the links between domestic violence, mental health and suicide prevention<sup>12</sup>, and work on strategies to reduce domestic violence and be responsive to those at highest risk of domestic violence.
35. Culturally responsive, peer-led services and community development strategies to engage communities within suicide prevention initiatives and postvention support (for survivors and families and friends bereaved by suicide) are needed.
36. Codes of conducts or other forms of moderation/regulation in addressing suicide prevention issues needs to be included as part of a National Suicide Prevention Strategy.

### PHAA resolves to:

37. Advocate for the development and implementation of social policies at Federal, State/Territory and local government levels that are the most likely to ameliorate structural conditions associated with suicide and self-harm, including unemployment, rapid economic change, socio-economic disadvantage and inequities.
38. Recommend that training programs be further developed and resourced, especially in rural and regional areas, to improve health and other allied workers' skills in assessing suicide and self-harm risk (especially depression), and in the treatment, coordinated discharge and appropriate referral of those at risk.
39. Advocate for the Commonwealth and State/Territory health departments to provide adequate funding to mental health promotion programmes to enhance social connectedness, particularly for young people. Community and hospital-based mental health services, and all types of non-government organisations providing mental health promotion, care and education, to promote access for children and young people and to improve the quality of programmes and services provided.
40. Support policies which reduce access to the means of suicide and self-harm, in particular firearms, motor vehicle exhaust fumes, and access to poisons and harmful medications.
41. Support the advocacy activities of Suicide Prevention Australia and Mental Health Australia on suicide prevention.
42. Advocate for well-resourced and culturally appropriate postvention support for survivors and families (including children) and friends bereaved by suicide, in recognition that postvention is 'prevention' for suicide.

43. Highlight the need for funding to support research into suicide and self-harm and the evaluation of the efficacy of preventive efforts. Research priorities include:
- Research on the social determinants of suicide in the Australian context.
  - Best practice on a national/state/local/community level to prevent and manage suicide.
  - Robust economic and outcome focused evaluations of national suicide prevention activities
  - The causes of suicide within high-risk populations, including people with a lived experience of mental health problems and disorders.<sup>16</sup>
  - Participatory action research with Aboriginal and Torres Strait Islander populations.<sup>5</sup>
  - The economic cost of suicide-related behaviour.
  - Improved collection of data (e.g. socio-cultural and demographic data) related to suicide and suicidality (e.g. self-harm) to identify vulnerable groups.

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