Public Health Association
AUSTRALIA

Suicide Prevention

Policy Position Statement

This policy covers prevention of suicide and support for those at risk of suicide.

Key messages: Every suicide death is a tragedy that has ripple effects across the community. Suicide is preventable through a multi-strategy approach. Suicide prevention policies and practices must address the underlying interpersonal, societal, ethnic, cultural, spiritual, and economic drivers of suicide and ensure people experiencing suicidal ideation or distress have easy access to a continuum of holistic wellbeing supports and services.

Key policy positions:

1. Update and fully resource a comprehensive national suicide prevention strategy and support the full implementation of the 2022 National Mental Health and Suicide Prevention Agreement, associated Bilateral Schedule and wellbeing literacy needs.
2. Update and fully resource a comprehensive national level suicide prevention strategy for Aboriginal and Torres Strait Islander people led by First Nations organisations and communities.
3. Develop specific strategies for high suicide risk groups (in addition to First Nations Peoples) including children and young people; middle aged men; lesbian, gay, bisexual, transgender, intersex, queer, intersex (LGBTQIA+) people; people from ethnically, culturally and linguistically diverse backgrounds (CALD) particularly refugees and asylum seekers; older adults; people who experience a disability or neurodivergence; and those living in rural or remote areas.
4. Resource ongoing State and Territory level suicide prevention policies and plans.

Audience: All PHAA members, governments, media

Responsibility: PHAA Mental Health Special Interest Group (SIG)

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Policy position statement

PHAA affirms the following principles:

1. In recognition of the complexity and interrelatedness of risk factors for suicide; suicide prevention policies and practices should be multi-strategy, multi-sectoral, interdisciplinary, address the underlying drivers of suicide and ensure people experiencing suicidal ideation or distress have easy access to a continuum of holistic wellbeing supports, and services.
2. Prevention policies and practices need to recognise that the rates and causes of suicide vary across age, gender, sexuality, race, religion, culture, social conditions, and location, and both universal and targeted approaches tailored to these communities are needed to prevent suicide.
3. People with lived and living experience of mental ill-health and/or suicidality should be involved in the codesign of policy, wellbeing literacy programs, and service system responses.
4. Care provided to people who may be suicidal should be recovery-oriented, person centred, trauma informed, ethnically, and culturally competent and developmentally appropriate.
5. In the aftermath of a suicide death, services and local communities should implement clear postvention management protocols to reduce the risk of suicide contagion and the potential for long-lasting negative effects on family members, friends, colleagues, and local community members along with the staff responsible for their care.
6. Implementing evidence-based strategies to prevent suicide and promote mental well-being and wellbeing literacy along with robust data collection to support evaluation and monitoring the effectiveness of these strategies, is crucial for reducing the burden of suicide across all levels.

PHAA notes the following evidence:

Definitions and causes

7. The Oxford Handbook of Suicide and Self-Injury[1] defines suicide as death caused by self-directed injurious behaviour with any intent to die as a result of the behaviour. Suicide can be both planned and reactive.
8. Suicide is complex and there is no one single cause. While suicide is often associated with a diagnosable mental health condition, not all people who die by suicide have a mental health condition.
9. The risk factors for suicide are multifactorial, operate at many levels and may overlap, including:
    - **Individual level** (e.g., experiencing depression or other mental health condition, harmful use of alcohol and other drugs, job loss and unemployment, poor wellbeing, poverty, chronic illness and disability, family history, history of childhood maltreatment, previous suicide attempts)
    - **Relationship/family level** (e.g., relationship breakdown, relationship conflict, loneliness, social isolation, and low level of social support, bullying and cyberbullying, gendered domestic and family violence)
    - **Societal and community level** (e.g., social determinants of health, homophobia/transphobia and other forms of discrimination, forced migration, dislocation and refugee status, conditions in detention centres and prisons, access to the means of suicide)

- **Political and economic factors** (e.g., economic downturns, policies on gun control, health and social care policies, human rights policies and conditions, the impact of colonisation and historical policies negatively impacting Aboriginal and Torres Strait Islander people (from here on, respectfully First Nations people).

10. A 2024 study into the burden of mental disorders and suicide attributable to childhood maltreatment found that childhood maltreatment contributes to a substantial proportion of mental health conditions (after controlling for genetic and environmental factors).[2] Efforts to prevent or mitigate the harms of childhood maltreatment should be a core element of a comprehensive suicide prevention response.[2]

The prevalence and impact of suicide in Australia

11. In 2022, there were 3,249 deaths by suicide – an average of about 9 deaths per day – with a crude death rate of 12.5 per 100,000 population[3].

12. Males are three times likely to take their own life than females, while females are more likely to attempt suicide or be hospitalised for intentional self-harm than males[3]. In 2022, 2455 men died by suicide, marking a 2.6% increase in the age-standardized suicide rate from 2021[3]. For females, there were 794 deaths, resulting in a 2.6% reduction in the age standardised rate from 2021[3].

13. In 2022, young and middle-aged people were more likely to die by suicide than those in older age cohorts. 81.7% of people who died by suicide were aged under 65 years[3].

14. From 2021 to 2022, the highest increase in age-specific suicide rates occurred in males aged 45-49 (up 9.4 deaths per 100,000) and females aged 70-74 (up 1.7 deaths per 100,000)[3].

15. From 2021 to 2022, the largest decrease in age-specific suicide rates were seen among males aged 80-84 (down 9.4 deaths per 100,000) and females aged 40-44 (down 1.6 deaths per 100,000)[3]

16. For young Australian aged 15-44 years, suicide is the leading cause of death in 2022. Suicide was also the leading cause of premature mortality with 108,762 years of life lost[3].

17. In 2022, there were 77 children aged 5-17 years who died by suicide. This is the lowest number of suicides of children in the 5-year time series presented[3].

18. Since 2001, age-standardised suicide rates among First Nations people have been higher than those of non-Indigenous Australians. The rate of death by suicide for First Nations males was 2.6 times that of non-Indigenous males. The suicide rate for First Nations females was 2.5 times that of non-Indigenous females. The rate of suicide deaths per 100,000 population among First Nations people was highest among 25–44-year-olds (50.0 deaths per 100,000 population). Among First Nations people aged 0–24 and 25–44, suicide rates were more than 3 times higher (3.1 each) than non-Indigenous Australians in the same age groups[4].

19. Other population groups at increased risk of suicide and self-harm include people with mood [affective] disorders[3], people having problems in spousal relationships[3, 5], those with a history of self-harm[3], those with acute and chronic substance abuse disorders including alcohol use disorders[3], people who use disability services[3, 6], ex-serving Australian Defence Force members[6], those with problems related to employment and unemployment[3], LGBTIQA+ people[6-8], men living in rural and remote areas[9], and emergency service workers[10].

20. For suicides, mood disorders, including depression, were the most common risk factors to be mentioned in all age groups, except those aged 85 years and over in 2022. Those aged under 45 years were most likely to have issues with psychoactive substance use (both acute use and intoxication, as well as chronic use) mentioned as a risk factor. Factors relating to employment and unemployment

were most commonly mentioned as a risk factor in those aged 45-64 years. Those aged 65 years and over were most likely to have chronic health conditions and pain mentioned as a risk factor[3].

21. In 2021–2022, there were approximately 26,900 hospitalisations due to intentional self-harm in Australia. Two thirds (67%) of these hospitalisations were females[6].
22. Between 2008–09 and 2021–22, the rates of intentional self-harm hospitalisations were consistently higher for young people. The highest hospitalisation rates in 2021–22 was recorded for aged 15–19 for both females (637 per 100,000 population) and males (152 per 100,000 population)[6].
23. Improving mental health and holistic wellbeing literacy is crucial in suicide prevention. Improvements in mental wellbeing can reduce the risk of suicide regardless of the presence or absence of a diagnosed mental health condition. This is because the risk of suicidal thoughts, feelings and behaviours can increase with decreasing levels of mental wellbeing[11].
24. The 'lived experience' of individuals who live with suicidal thoughts, have survived a suicide attempt, have been bereaved by suicide, or care for and support someone who is or was suicidal, commonly reflects that receiving support from health staff grounded in genuine, compassionate, and kind care significantly contributes to the restoration of their self-worth [12-14]. However, evidence highlights that the health systems often fail to provide adequate care for individuals presenting with suicidal ideation, characterized by a lack of empathy, an excessive focus on risk management, and disjointed services.[14,15]

Priorities for Policy, Practice and Research

25. Mental wellbeing promotion and preventive mental health:
    - Maximise protective factors for mental wellbeing to reduce suicide risk[16].
    - Implement strategies to address protective factors linked to suicide risk and ensure approaches are strengths-based, culturally appropriate, and community-led.
26. Community engagement and education:
    - Implement comprehensive mental health and wellbeing literacy and suicide awareness public campaigns. As well as provide training in mental health first aid and suicide awareness to ‘gatekeepers’ in all education, health, community and social service settings.
27. Integrated care and collaboration:
    - Ensure supports and services for people at risk of suicide or who have attempted suicide are holistic, compassionate, person-centred, trauma-informed and culturally safe.
    - There is significant impact of suicide on families, child survivors and friends in terms of mental health and wellbeing[17]. Therefore, social support for those affected should be considered within suicide prevention strategies.
    - Support for those hospitalised due to intentional self-harm and those at risk of suicide should include appropriately supported discharge planning along with support for the zero-suicide model (which includes continuous contact and support with survivors after acute care)[18].
28. Data collection and surveillance:
    - Improve data collection, surveillance, and reporting mechanisms at all levels to better understand the prevalence, trends, and risk factors associated with suicide, and inform and enhance targeted prevention efforts.
29. Research, continued learning and training:

- Prioritise research investment to identify effective interventions, evaluate existing programs, and innovate suicide prevention strategies, emphasising evidence-based practices and continuous improvement.
- Foster a culture of suicide prevention learning throughout organisations, one that promotes continuous improvement, value in research, nurtures reflective practice and critical thinking, appreciates employee contributions, and encourages experimentation with new ideas[18]
- Focus the delivery of compassionate, kind and non-discriminatory care as a fundamental element within the training for relevant healthcare practitioners.

30. The Sustainable Development Goals make specific reference to mental health. Target 3.4 requests that countries: "By 2030, reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and wellbeing." Within Target 3.4, suicide rate is an indicator (3.4.2). Implementing this policy would contribute towards the achievement of UN Sustainable Development Goal 3: Good Health and Wellbeing.

PHAA seeks the following actions:

31. Building a health workforce that prioritizes therapeutic engagement, incorporates peer support workers, and is attuned to the significance of complex trauma in various presentations, moving beyond a primary focus on risk management.
32. Integrate a focus on positively changing the balance of risk and protective factors to enhance individual and community mental wellbeing, and wellbeing literacy initiatives across all government policies and programs.
33. Invest in tailored, multi-sectoral and community level interventions for high-risk populations, including ongoing resourcing of training for health and other workers to promote the identification of those at risk of suicide and self-harm.
34. Prioritise lived experience expertise in designing and implementing suicide prevention strategies through genuine co-design processes.
35. Ensure culturally appropriate and trauma-informed care to improve access for First Nations and CALD communities[19].
36. Combat stigma and expand pathways to mental health care, and wellbeing literacy emphasizing early interventions and support across various life transitions and settings[20].
37. Recognise the importance and need for data, evidence, and outcomes in developing national outcomes frameworks and standards for suicide prevention efforts.

PHAA resolves to:

38. 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.
39. 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.

40. Advocate for the Commonwealth and State/Territory governments to provide adequate funding to mental health promotion programmes to enhance social connectedness.
41. 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.
42. Advocate for well-resourced and ethnic, 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 determinants of suicide in the Australian context.
    - Impacts of wellbeing literacy programs.
    - 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 suicide[3, 6, 20].
    - Participatory action research with Aboriginal and Torres Strait Islander populations[13].
    - 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.

(Adopted 2018 and revised 2012, 2015, 2018, 2021 and 2024)

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