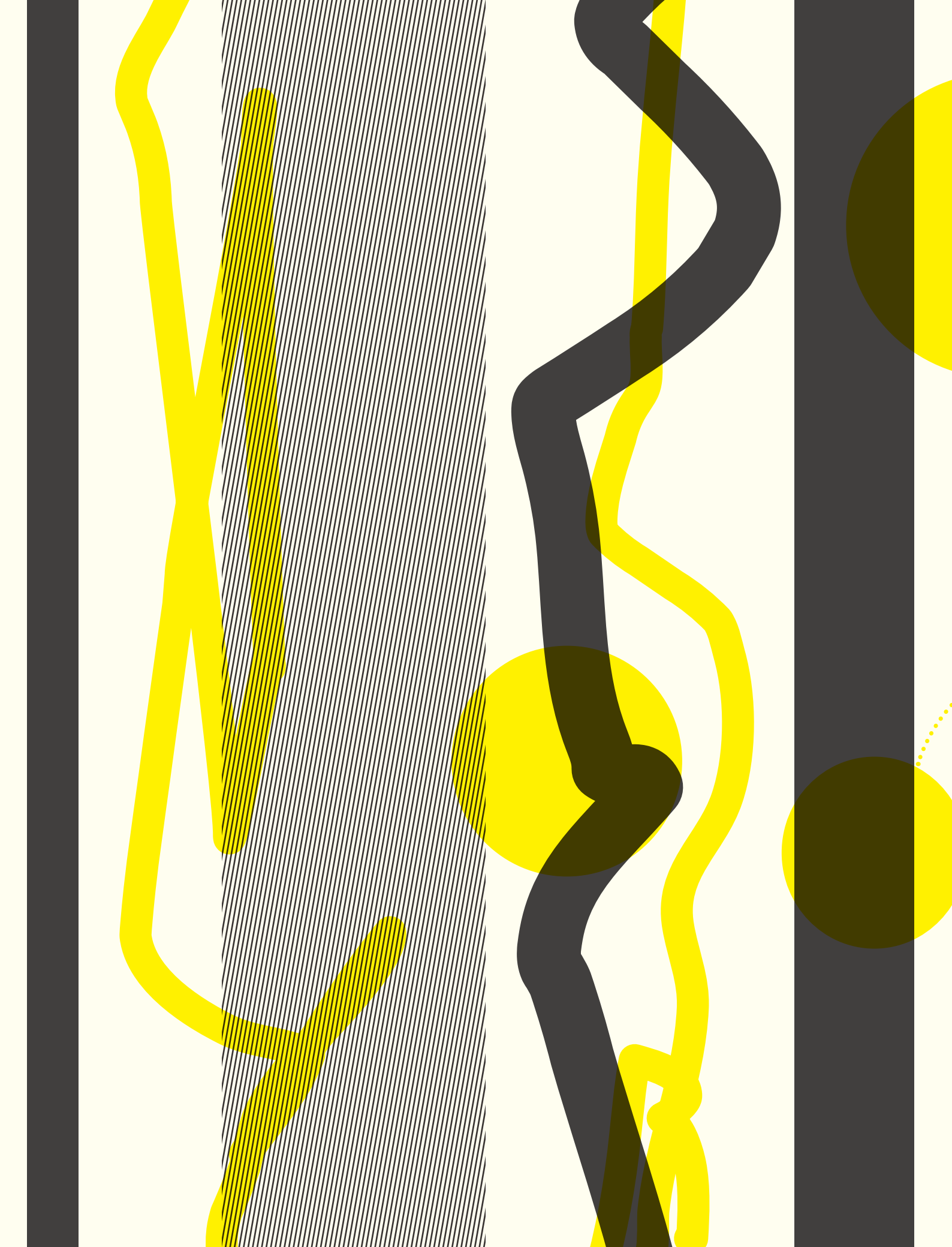

PREVENTION
of Suicide

WHY SUICIDE PREVENTION IS EVERYONE'S BUSINESS

by Alan Woodward

Suicide affects thousands of Australians. Its impact is widespread. The phrase, suicide prevention is everyone's business, is often mentioned in suicide prevention strategies, but it is unclear why or how this is so.

We have to move in Australia from our old understandings of suicide as an isolated behaviour by the mentally ill to a tragic loss of life that occurs when an individual perceives, irrationally and perhaps because of underlying mental health disorders, that the best step they can take for themselves, and for others, is to end their life. We need to accept that the motivational factors for suicidal behaviour occur in the context of how an individual views themselves and the world around them.

We need to better understand why people die by suicide and what can be done to prevent such tragic deaths so that in all of our communities we understand why suicide prevention is everyone's business.

Each year, in Australia, about 2200 people die by suicide, according to the Australian Bureau of Statistics (ABS) causes of death reports. This number has remained stubbornly around the same level for the past decade. The ABS National Survey of Mental Health and Wellbeing reports 65,000 attempts of suicide each year. Around 38,000 of these are recorded through interactions in our health system, principally at accident and emergency departments of public hospitals, as reported by the Australian Institute of Health and Welfare. Estimates from research (Botha et al: 2009) are that around 21,000 people throughout Australia are impacted by another's suicide each year – in the past decade a population the size of Wollongong has grieved the loss of a friend, a brother, a father, a sister, a football team member or a work colleague.

Mental illness is frequently behind the torture and pain of the person who chooses to end their life. In his book on suicide prevention published in 2008, Australian researcher Professor Robert Goldney from the University of Adelaide identified that more than 70% of people who died by suicide would have been diagnosable with clinical depression at the time of death. This figure is replicated in international research. Clearly, mental illness and, especially mood disorders such as depression, play a big part in suicidal ideation and action.

Yet the pathological elements do not fully explain suicidal behaviour. A simple causal link does not exist. There is more to suicide than this: research going back to the 1960s by Dr Ed Shneidman and his colleagues, and recorded in the book The Suicidal Mind (1996), described the experience of psychological pain in a crisis state as a precursor to a suicidal impulse. Trigger factors and events often precipitate this state of crisis, for example, a relationship ends, a job is lost, a humiliating situation occurs, the money runs out.

More recently Professor Thomas Joiner at Florida University developed an interpersonal theory of suicide, drawing on psychological autopsies concerning people who have died by suicide; this model approaches suicidal ideation from the perspective of psychosocial factors that influence how a person views themselves and the world around them. These forces may create the notion that suicide is a preferred option – a person comes to the belief that the world will be better off without them. Additional perspectives on suicide are identified by researchers in the United Kingdom, including Professor Rory O'Connor of the University of Stirling, who, in the 2010 International Handbook of Suicide Prevention: Research, Policy and Practice, present an integrated motivational-volitional model. This shows the inter-relationships between background factors and motivational factors, which spur a person onto suicidal behaviour.

A STRONG CHALLENGE TO SUICIDAL THINKING, THEREFORE, IS THE MESSAGE: 'YOU ARE NOT ALONE'.

Alan Woodward
Executive Director
Lifeline Foundation for Suicide Prevention

This research tells us that perceptions around burdensomeness and thwarted belongingness, as Joiner terms them, a sense of hopelessness, feelings of being alone and unable to cope with life's difficulties and see options or solutions, play a very real part in suicidal behaviour – and therefore must be addressed in suicide prevention.

Through a greater understanding of these psychosocial factors we may see more clearly how suicide prevention is everyone's business.

Support services

To illustrate the relevance of helplines in suicide prevention, 43.6% of calls to the Lifeline telephone crisis line have as a main issue presenting for the caller an aspect of their relationship with family and friends. Moreover, in 32.7% of calls, issues around the caller's sense of themselves and the social scene surrounding them are raised as features of the need for help. Loneliness is expressed as a crisis support issue in 14% of the calls; almost a quarter (23%) of these calls is from people who are actually living with others.

A strong challenge to suicidal thinking, therefore, is the message: 'you are not alone'.

This is the thinking behind helplines as non-judgemental and accessible services for people to contact when seeking help, with research in Australia and internationally suggesting between 25 and 30% of callers to such services are experiencing suicidal ideation at the time of the call.

It is also the thinking behind community campaigns such as R U OK? Day, which reinforce the power of positive conversation in supporting another's wellbeing and encourage help-seeking when times are tough, including the promotion of helplines and crisis support services.

Friends and families

All of us live with connections to family and friends and to communities, in various forms, including our local area. Our experiences of these connections impact on our psychosocial outlook and we, in turn, influence the impacts on others. Accordingly, we can influence how the psychosocial factors operate for a person. We can, through our actions to show compassion and acceptance of people experiencing difficulties, and through giving them encouragement to seek help, interrupt the steps a person may be taking on the road to suicide.

Social exclusion

Social exclusion is of particular concern because of the direct attack it can have on a person's perceptions of belongingness. Very high rates of suicide among populations which are vulnerable to discrimination seem to bear this out; persons of indigenous background are 2.5 times the general population dying by suicide, persons identifying as lesbian, gay, bisexual, transgender and intersex are estimated to at least 3.5 times more often die by suicide. Discrimination on the basis of race, sexual preference, gender or disability heightens risks of suicide for some individuals.

An inclusive and accepting society is a suicide-safer society. Our efforts to directly remove social exclusion and discrimination from our communities contribute to suicide prevention.

There is also a socioeconomic disadvantage aspect to the spread of psychosocial factors in the Australian population. Most recently, the Council of Australian Governments Reform Council's Report on Healthcare Performance for 2011–12, for the first time reporting on measures of psychological distress, found that in 2011–12, people living in the most socioeconomically disadvantaged areas were more than twice as likely to experience distress levels as those in the least disadvantaged areas.

We understand now that psychological distress can foreshadow the onset of mental illness; the crisis state that occurs surrounding this distress can give rise to suicidal ideation. A more equitable society will support suicide prevention.

What we can do

In considering how suicide prevention is everyone's business, therefore, we need to give greater attention to the psychosocial factors that are associated with the development of a heightened intention to die.

While few of us are able to provide the clinical treatments and programs to address mental illness, we are all able to contribute to suicide prevention in the following practical ways:

- *Building the protective factors that reinforce positive wellbeing in how those around us regard themselves and their social environment.*
- *Creating stronger social networks, an inclusive Australia.*
- *Promoting help-seeking and the provision of caring responses to others in times of personal crisis.*

In all of this, suicide prevention is everyone's business.

PREVENTING SUICIDE ACROSS SECTORS & COMMUNITIES

by Susan Murray

Chief Executive Officer, Suicide Prevention Australia

In December 2012 the Lancet reported that globally in 2010 suicide took more lives than war, murder and natural disasters combined; 36 million years of healthy life were lost in that same year alone.

Where are the protests, the community outrage at these figures? Where is the justice? Where is the funding for a concerted long-term, multi-faceted whole-of-community effort to turn this around?

Perhaps the numbers are too big to grasp. Perhaps we need to individualise it as someone's daughter; a sister's brother; a child's father. What will make our community sit up and take notice of this unacceptable wicked social predicament?

Some decades ago the leaders of community-funded organisations, the state cancer councils and the National Heart Foundation, recognised that smoking was the most significant preventable cause of ill-health and thus began a concerted community education and advocacy program. Today, Australia is recognised globally as a leader in tobacco control. The rates of smoking have dropped below 20% (across the population) not because of the work of a few people but because, layer by layer, the whole community was educated about the ill-health effects of smoking and individuals were supported to quit. Government legislation and policy implementation, fiscal imposts, supportive environments like smoke-free workplaces, and controls on advertising were just some of the initiatives that combined across the whole community to achieve this remarkable turnaround.

It is this approach that needs to be adopted for prevention of deaths by suicide. Australasia has a small population and it is ageing. It cannot sustain 111,700 healthy years of life lost annually (GBD: 2010).

No one factor can be held to account if a person decides to take their own life. It is this multiplicity of factors that have made it so difficult to gain traction in reducing suicides in Australia. A review of the statistics published by the Australian Bureau of Statistics and the Australian Institute of Health and Welfare shows just how hard it has been to make headway in reducing deaths from suicide. Deaths have plateaued for all people over the last decade. Certainly the focus on reducing youth suicide has led to a decline in young people taking their own life – and this is extremely praiseworthy.

It must also be sustained. Every year another cohort of young people faces the challenges of gaining an education and securing employment, maintaining strong and supportive family structures and remaining connected to those who can help in troubled times.

What is good practice?

Suicide Prevention Australia (SPA) strongly agrees with the World Health Organization

WE ARE UNDER NO ILLUSION ABOUT THE CHALLENGES WE FACE BUT WITH STATISTICS HAVING PLATEAUED THE CHANGE IN OUR APPROACH CANNOT COME SOON ENOUGH. COLLECTIVE IMPACT IS THE WAY AHEAD TO PREVENT SUICIDES IN AUSTRALIA.

and the National Mental Health Commission that suicide prevention requires an innovative, comprehensive multi-sectoral approach. This includes health and non-health sectors, for example, education, employment, justice, immigration and media.

Interventions in high-risk groups and settings and appropriate responses to individuals identified at imminent risk of suicide are needed to reduce suicide rates across the entire population.

There is evidence to support strong components of action such as:

- Improved awareness and skills for frontline personnel, whether they be general practitioners and ambulance services, families, schools or work communities.
- Improved mental healthcare.
- Restricting access to the means individuals may use to end their lives (NMHC: 2012, 139).
- Using the emerging evidence that supports new e-health services as positive ways to increase access and timely interventions. The evidence suggests that more intensive approaches are needed to follow up after a suicide attempt, beyond standard discharge procedures. This means supporting people for up to 12 months after their suicide attempt (NMHC: 2012, 139).

What does the future hold?

We must continue to invest resources into this intractable and wicked social problem. Why? Because human lives are at stake.

How can we change our approach to begin to show a downward trend in national suicide statistics? The National Coalition for Suicide Prevention, created within the principles and framework of Collective Impact, is crucial in this respect.

Collective Impact is a structured and sophisticated approach that is much more valuable than the sum of the parts. It has shown great promise in communities in the United States addressing intractable social problems. Members of the National Coalition firmly believe that it has potential to make a difference in suicide prevention in Australia.

But it will take a lot of effort and engagement just as we have seen in smoking control. Similarly the most successful US initiatives have engaged all three sectors – community –like SPA, businesses –small, medium and large –, and government – local, state and federal.

First published in Stanford Social Innovation Review, there are six elements to successful Collective Impact:

- An agreed common agenda to which all participants will commit.
- Shared goals and measures.
- A common reporting framework.
- Mutually reinforcing activities.
- Continuous communication.
- A backbone organisation to drive the common agenda.

At its heart Collective Impact enables us to solve challenging social problems with currently available resources, as illustrated in a Collective Impact success story. First documented in the US, the Strive education initiative – cradle to career – was developed over the second half of the 20th century, when the US dropped from being world leader in high school graduates to 18th among the top 24 industrialised nations. Individual schools had good results but there were no system-wide improvements.

Strive brought together 300 leaders in heads of private and corporate foundations, city and government officials, presidents of eight universities and community colleges, and executive directors of hundreds of education and not-for-profit organisations. They agreed on:

- The common agenda – improve education participation rates at every stage of life from cradle to career.
- Goals, measures and reporting – develop a single set of goals for 15 student success networks, which then measured and reported in the same way.
- Mutually reinforcing activities – rather than develop new activities, the 300 organisations charted their own course consistent with the common agenda and informed by shared measures and results.
- Continuous communication – the major challenge when bringing such diverse players together was building trust, which we did through facilitating communication within – and across – the network.
- Backbone organisation – Collective Impact needs a backbone; it controls everything. This is a separate organisation responsible for driving the agenda, maintaining the communication and mediating conflicts among stakeholders, a role that Strive played. They leveraged their own $1.5million budget to coordinate organisations with a combined budget of $7 billion – a figure only most of us can dream about.

What do we want to achieve?

We want to halve the number of suicides; we want to halve the attempts. That is our agenda – to reduce suicides in Australia by 50% over the next decade.

The formation of the National Coalition for Suicide Prevention includes more than 20 not-for-profit organisations. – beyondblue, Lifeline, Black Dog, R U OK?, SANE , LGBTI (lesbian, gay, bisexual, transgender, intersex) Health Alliance and many others. All of them are committed to making this change.

SPA is to be the backbone organisation. We are under no illusion about the challenges we face but with statistics having plateaued the change in our approach cannot come soon enough. Collective Impact is the way ahead to prevent suicides in Australia.

TIME to FOCUS on PREVENTION of MENTAL HEALTH DISORDERS

by Prof Helen Christensen
Executive Director, Black Dog Institute, UNSW, Randwick, Sydney
& Katherine Petrie
Black Dog Institute, UNSW, Randwick, Sydney

Nearly a decade ago, Gavin Andrews at the Clinical Research Unit for Anxiety and Depression (CRUfAD), at St Vincent's Hospital and the University of New South Wales (UNSW), determined that preventing depression could lower the disease burden by 22%, the same percentage as that associated with optimal treatment. However, the prevention of depression and common mental health disorders in general, has not been a focus of research effort or of health practice in Australia.

A recently published report on Australian research priorities in mental health reveals that prevention in mental health remains radically underfunded (Christensen, Batterham, Griffiths et al: 2013, 355-62), despite its considerable unrealised potential. Epidemiological, treatment and neurobiological research has dominated in the last 10 years. Competitive grant funding for prevention and promotion has been low, in fact declining between 2000 and 2008 relative to other funding.

Depression is a major contributor to the global burden of disease, making it an important target for prevention. In the Institute of Health Metrics and Evaluation's Global Burden of Disease Study (IHME: 2013), depression ranked eleventh among disorders responsible for the global disease burden (a 37% increase since 2002) while, in Australia, major depressive and anxiety disorders were the seventh and eleventh leading causes of disease burden respectively (DALYs) (IHME GBD Profile: 2010). This worldwide burden of mental health disorders is projected to rise dramatically in coming decades (Mathers and Loncar: 2006).

We believe promoting the prevention of common mental health disorders in the first place should be a focus for research, practice and prevention activities.

What is prevention?

Prevention encompasses any intervention aimed at preventing the onset of new cases of mental disorder in those who do not currently meet criteria for the disorder (US Institute of Medicine: 2009). Prevention can target the whole population (universal), high-risk groups (selective) or those displaying early symptoms but do not yet meet criteria for a clinical diagnosis (indicated).

Prevention needs to be distinguished from mental health promotion, which primarily aims to promote positive mental health practices. Prevention, on the other hand, aims to stop people at risk from developing the disorder. It is also different from early intervention, which, strictly speaking, refers to the timely intervention of treatment to individuals who already have significant mental health problems, usually of a level to warrant diagnosis. In short, prevention applies specific techniques, programs or interventions in groups of people who are at risk of mental health disorders so that they do not develop such a disorder. Examples of prevention activities include the Triple P Program to prevent development of childhood conditions in young children, MoodGYM in the prevention of depression and anxiety in adolescence, physical activity programs in older adults to prevent vascular depression, drug and alcohol programs that stop youth from taking up illicit drugs, and building barriers to prevent suicide attempts at suicide hot spots.

We are focusing on prevention rather than treatment for three reasons.

- Treatment alone will never be enough to lower the disease burden associated with mental health disorders. Despite currently available and effective treatments, treatment on its own will not avert this high disease burden given the increasing prevalence and consequent demand for services. Andrews and colleagues (2004: 526-33) for example, found that treatments averted only 13% of the disease burden of depression. Even with improved coverage, competent clinicians and adherence to treatments, only 36% of depression could be averted using current knowledge and therapies, failing to address the remaining burden of major depression (Andrews, Issakidis, Sanderson et al: 2004, 526-33). Prevention is likely to be the single biggest contributor to lowering this burden.
- Prevention is better than a cure. If something can be prevented ahead of time, it will always remain a better option than treatment, particularly in terms of the suffering averted.
- Prevention works. Strong evidence that depression can be prevented includes meta-analysis by Munoz and colleagues in 2010 of over 30 randomised controlled trials (RCTs), which demonstrated prevention interventions can lower the incidence of new episodes of major depression by around 25%, and up to 50% for stepped-care preventive interventions. A recent report in the Journal of the American Medical Association (Cuijpers, Beekman, Reynolds et al: 2012, 271) reviewing additional research trials reinforced similar conclusions.

Effective preventive strategies from these high-quality prevention trials include psychotherapy and psychoeducation. Such interventions may also be cost-effective, particularly in the long term, by averting considerable future costs of treatment, disorder-related disability, unemployment and reduced productivity (Smit et al: 2006, 330-336; Cuijpers et al: 2012). Prevention of mental health disorders can also reduce the global disease burden and ease over-stretched medical and treatment services (Munoz: 2010).

Prevention in children & adolescents

Prevention programs for children and adolescents are likely to have the greatest long-term benefit and best bang for buck. A recent systematic review in Australia identified screening and psychological treatment, and screening and bibliotherapy (brief self-guided manualised Cognitive Behaviour Therapy), as two cost-effective strategies to prevent

anxiety and depression in children and adolescents (Vos, Carter, Barendregt et al: 2010). With half of all cases of mental disorder experienced in a lifetime beginning by age 14, and three-quarters by age 24 (Kessler et al: 2005: 593-602) this is a critical time to implement prevention.

Ricardo Munoz, an internationally recognised professor with expertise in prevention and treatment of depression, and colleagues note that if caught early enough and implemented systematically, prevention could prevent development of disorder, or at least delay first onset and establish a solid foundation of effective coping strategies and cognitive skills (Munoz et al: 2010; Munoz: 2010). There is relatively strong evidence that school-based prevention and early intervention programs can prevent and treat these mental health disorders (Merry et al: 2011; Neil and Christensen: 2009, 208-215). Schools are an ideal environment for systematic implementation of prevention strategies to a large, captive audience (Calear et al: 2009, 1021-32), with stepped-care interventions also feasible in this setting.

Between 2006 and 2007 Alison Calear and colleagues conducted an RCT of an online self-help cognitive-behavioural therapy (CBT) program, MoodGYM, in 30 schools across Australia, aiming to prevent and reduce symptoms of anxiety and depression (Calear et al: 2009). Anxiety symptoms in students completing the MoodGYM course were reduced significantly as were depression symptoms for young males. Furthermore, a smaller percentage of students in the intervention group developed clinical levels of anxiety, and significantly fewer males developed depression post-intervention and at six-month follow-up. This case study suggests the utility of an online self-guided CBT program to treat, and potentially prevent, depression and anxiety in adolescents.

Yet prevention does not get its due recognition. It is not prioritised, we believe, because of the following barriers:

- Resources are already stretched in mental health when even basic treatment is not available. Short-term, focused treatment is more important than longer-term preventative measures.
- Many mental health practitioners are not convinced by the research evidence.
- Prevention needs to cover a wide population to pick up individuals at risk. This extends beyond the medical system to workplaces, schools and universities, and a broader audience who may not be easy to reach. Human resource managers, CEOs, school principals, teachers and families need to get involved.
- Prevention can be expensive, although using the internet means programs can be widely disseminated online at relatively low cost. Virtual clinics with mental health prevention programs, like mindhealthconnect (http://www.mindhealthconnect.org.au/), allow for centralised access to online resources.
- The implementation science of prevention is not fully formed. Although we have promising programs, prevention interventions require the same degree of rigorous clinical evaluation as other medical devices or pharmaceuticals, and many programs are not yet ready to be disseminated (Flay et al: 2005, 151-75).
- The public needs to engage with prevention programs to date. This requires individual effort, but if you have no symptoms of depression, why would anyone think of engaging with a CBT prevention program?
- There are few champions for prevention or prevention research.

So how can we promote the importance of prevention?

Solutions to these barriers may include:

- Convincing policy makers of the long-term importance of prevention by providing real-life scenarios and solid economic arguments. The prime driver will be leadership – recognition by those in power that prevention is needed combined with the strength to take money away from treatment or recovery programs that are uneconomical.
- Convincing health professionals of the importance of prevention by demonstrating and implementing best-practice evidence-based programs.
- Convincing workplaces that prevention is required. Employers are concerned about the costs of depression to the workplace and recognise that mental health problems are a major contributor to workplace disability. We need more evidence about how much money prevention in the workplace saves.
- Introducing prevention programs should be introduced into the school curriculum and the effects publicised on relevant outcomes, such as academic performance and school attendance. Making the outcomes broader than mental health will help convince teachers of the importance of prevention activities.
- Harnessing the power of technology to promote effective prevention trials and programs.
- Investing in prevention research to consolidate promising programs for later dissemination.
- In the future, designing new prevention programs that will rely less on the initiative of the recipient. If we can engineer the environment to promote prevention activities (such as erecting barriers at hot spots to lower the risk of suicide), or legislate to enforce preventative practices, it will make it easier to adopt them. Gaming technology may help in promoting some activities, such as exercise (for example, https://www.zombiesrungame.com/) or cognitive behaviour therapy (Merry et al: 2012).
- Finding prevention champions, for instance, the formation in 2011 of a Global Consortium of Depression Prevention (http://www.preventionofdepression.org/), which includes Australian researchers such as (will need to work out how best to add these websites, perhaps best to put in Reference list) Patrick McGorry (ORGYEN Youth Mental Health), Andrew Chanon (ORGYEN Youth Mental Health), Catherine Mihalopoulos (Health Economics Unit, Deakin University, Melbourne),Kathy Griffiths (Australian National University, Canberra) and Helen Christensen (Black Dog Institute, UNSW), and the newly established national Alliance for the Prevention of Mental Health Disorders (officially launched in May 2013 in Canberra) . The Alliance supports an increased focus on population health to prevent mental disorders and promote emotional wellbeing (Jacka et al: in press). The Rotary Health Foundation will also consider prioritising funding for prevention.

Treatment alone is unlikely to be enough to reduce the burden of mental health disorders whereas we know prevention is both effective and cost-effective. It is finally – and definitely – time to focus on prevention.

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