



Black Dog Institute

What can be done to decrease suicidal behaviour in Australia?

A call to action.

October | 2020



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We wish to thank the following individuals for their review of this report:

Caroline Allen | Ann Dadich | Leilani Darwin | Carrie Lumby | Nicole Scott | Claire Thompson

Although the reviewers listed above provided many constructive comments and suggestions, they were not asked to endorse the report’s conclusions or recommendations, nor did they see the final draft of the report before its release.

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Foreword

In Australia, suicide rates have continued to rise over the last decade. The challenge to bend this curve is immense. One of the biggest challenges of contemporary suicide prevention is that initiatives, policies and programs to prevent and respond to suicide are often unable to benefit from research evidence. This is not so much because this evidence is ignored, but because in many cases it does not exist.

In response, I’m delighted to present *What can be done to decrease suicidal behaviour in Australia? A call to action*, a white paper from the Black Dog Institute that takes a major step towards addressing this critical research gap. As one of only two medical research institutes in Australia dedicated to mental health and suicide prevention, we take seriously our role to support and guide the development of strategic, evidence-based suicide prevention policy, programs and services, both within the Institute and beyond.

This white paper is our contribution to the contemporary conversation on suicide prevention in Australia. It builds on the tireless efforts of our peers and collaborators in the suicide prevention domain over the last decade to present a body of new and synthesised knowledge across four key areas:

- Meeting the needs of people in suicidal crisis with new models and integrated care
- The impact of social determinants on suicide and how policy settings can help
- Suicide awareness campaigns: are they a valid prevention strategy?
- Views regarding new directions in innovation in suicide prevention

This document is an exploration and review of the existing data as it relates to suicide prevention and delivers a series of evidence-based recommendations to guide suicide prevention initiatives. Each chapter is a standalone section written by leading researchers within the Black Dog Institute and shaped by their unique voices.

In developing this white paper, we turned to those whose experiences must guide current and future conversations around suicide prevention. Our draft content was reviewed by people with lived experience of suicide—the real innovators in shaping our newer models of care—as well as by an Indigenous reviewer who provided a crucial Aboriginal and Torres Strait Islander perspective on our work.

The inclusion of this expertise reflects the way we work at the Black Dog Institute: informed by evidence, shaped by the communities we serve, and leading through science, compassion and action. And, with the Federal Government now re-committing efforts towards reducing suicide, there has never been a more critical time to provide a clear evidence base to support these efforts.

We are proud to deliver research commentary on major issues confronting Australia in suicide prevention. Now, we are keen to hear your voices refine and extend our recommendations as we walk together to achieve the change that we need to see.



Helen Christensen

Helen Christensen
Director, Black Dog Institute





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Executive Summary

What can be done to decrease suicidal behaviour in Australia? A call to action represents an opportunity to consider emerging research and experiential evidence and its potential to drive system reform and reduce suicide.

More people die by suicide than in road accidents every year. The causes of and motivations behind suicide are complex, influenced by factors such as a person's age, gender, sexual orientation, socioeconomic status and cultural background, as well as the intersections between them. Contributors to suicidal crisis can include historic or distal factors such as childhood adversity, family history of suicide or mental illness, and previous suicide attempt, as well as proximal factors like physical and mental health problems, discrimination and a range of adverse life events (e.g. interpersonal conflict, relationship breakdown, disrupted community or cultural obligations, unemployment, housing, financial or legal problems)²⁻⁵. Distal risk factors can increase the likelihood of and vulnerability to proximal factors, and the effects of these events can accumulate over a person's lifetime, becoming sources of significant trauma.

The Australian approach to suicide prevention has changed significantly in recent years. Critical shifts in government funding of suicide prevention research and implementation have occurred, specifically with respect to multi-level approaches in which regional suicide prevention alliances guide the simultaneous implementation of a number of evidence-based strategies, such as community training, school-based programs, improved media reporting of suicide, means restriction and improved crisis response. Access to best evidence-based medical, psychological and psychiatric treatment and workforce training is also a crucial element. The

impact of Black Dog Institute's LifeSpan integrated suicide prevention framework and other multi-level models of suicide prevention in Australia are not yet known. However, an international review of all evidence on suicide prevention concluded that no single strategy is superior to another; rather, combinations of both individual-, community- and population-level strategies should be assessed with rigorous research designs⁵. While each of these models, if implemented well and with enough reach and dose, can prevent many suicides, more is required to decrease the high and continued rates we are seeing and ultimately prevent suicide.

These evidence-based practices must be supported by policy settings that focus on improving the social conditions in which people live so that regional, state and national strategies are working hand-in-hand. Understanding which policy features can reduce suicide risk is particularly important in Australia now, with the National Suicide Prevention Taskforce (NSPT) advising the government to consider myriad policy responses to mental health and suicide prevention. This has already occurred to some extent with the response to the COVID-19 pandemic via higher welfare payments, employee payments and tax relief measures.

This white paper is a call to action to extend the tremendous work that has been accomplished to date. We have chosen to focus on four priority areas across all ages in suicide prevention based on emerging priorities and opportunities: new models of care, social determinants of health,

suicide awareness campaigns as well as scientific and research innovations in suicide prevention. Thematic chapters address each of these important topics, drawing on the best available evidence and lived experience wisdom. Each chapter was reviewed by individuals with lived experience, as well as an Indigenous reviewer.

Chapter 1: Meeting the needs of those in suicidal crisis with new models and integrated care

Evaluation of the research base is a critical first step to guide evidence-based suicide prevention policy⁶; however, the experiential wisdom and evidence from lived experience perspectives are equally important. Chapter 1 draws upon the research evidence base and is underpinned by lived experience wisdom. Individuals with lived experience of suicide have indicated the health system often fails to provide effective care. Even when current best practice is applied, the support needs of many help-seekers goes unmet. Further, many people experiencing suicidal distress never seek help from mainstream services. Consequently, there is a need for new models of care that meet the needs of people with lived experience.

There is considerable government investment in new services across Australia; however, there is limited empirical evidence regarding the most effective alternatives. Crisis models of care are largely reactive rather than proactive, but emerging evidence suggests that alternatives to these models, such as safe haven cafes or respite spaces, are required in non-clinical settings and can proactively and respectfully meet the needs of some individuals experiencing crisis⁷. These

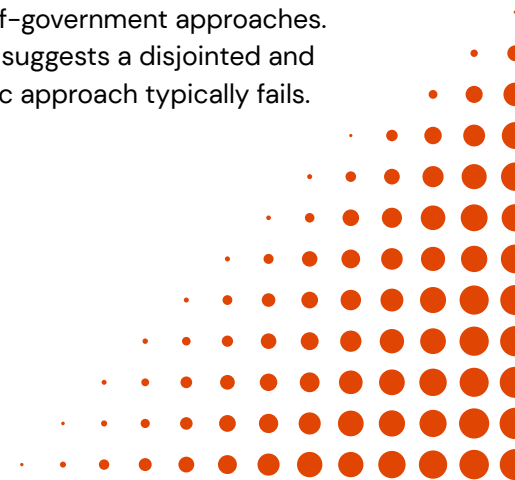
alternative models are often staffed by trained peer workers or volunteers, some with their own lived experience of mental illness and/or suicidality, who sit with visitors to discuss their feelings. These models can reduce the burden on existing services, including ambulance services, police services and emergency departments, and thus can be cost effective⁸.

Digital interventions that directly target suicide can reduce suicidal ideation⁹. The recent emergence of peer telephonic warm line models reflects community demand for telephone-based support. Online communities can provide stigma-free social connections¹⁰, yet there is limited research regarding their effectiveness in reducing suicidal thoughts. This clearly represents an opportunity worthy of examination.

Digital offerings, including automated text messaging applications, can reduce suicidal ideation when they directly target suicide⁹. Telephone, internet and digital automatised and blended interventions can provide scale and reach and might also be the preferred conduit to care among individuals who prefer these modes.

Chapter 2: The impact of social determinants on suicide and how policy settings can help

Suicide prevention is complex and needs to be addressed by whole-of-government approaches. International evidence suggests a disjointed and psychologically specific approach typically fails.



An integrated approach to suicide prevention must encompass the social, economic and physical environments in which we live, known as the social determinants of wellbeing¹¹. Understanding how social determinants impact suicide is pivotal to improving policies and practices to redress social inequalities and prevent suicide at a population level.

Governments have a range of policy levers that can influence population-level outcomes by addressing social inequalities.

This chapter reviews the evidence on how to influence health, economic and social policies as they relate to suicide outcomes. A review of relevant scientific literature produced by the Black Dog Institute identified policy areas associated with suicide, including unemployment; limited welfare support^{12,13}; untimely access to treatment for mental illness^{14,15}; the pricing and taxing of alcohol¹⁶; access to the means of suicide^{17,18}, like weapons and toxic substances; punitive justice and detention policies¹⁹; LGBTQI+ marriage equality legislation²⁰; and precarious periods of social instability, like that during global pandemics²¹.

What remains unclear is which policies and policy settings are likely to be the most impactful whilst still being cost effective. The evidence for each policy area requires systematic review to clarify what is known, what remains unknown, the priorities to address and how to address them.

A more targeted approach could include investing in impact and economic modelling to identify the

specific interventions with the greatest capacity to reduce suicide risk, incorporating mental health and suicide risk impacts in policy and service decisions, reviewing evidence to clarify which policies have the greatest capacity to reduce suicide and conditions required to support and sustain these reductions, and investing in research to evaluate the impact of policy changes. This could occur within the World Health Organisation's life course framework to address social determinants from the pre-natal phase through to older age, thus demonstrating cumulative impacts of social determinants across the lifespan.

Chapter 3: Suicide awareness campaigns: are they a valid prevention strategy?

Suicide public awareness campaigns to address rising rates of suicide, typically delivered via mass media, have become increasingly popular²². In Australia, the past two decades have witnessed significant national and regional, government and philanthropic initiatives undertaken to prevent suicide. These involve at least some element of awareness raising, yet tend to blend these components with broader suicide prevention strategies or focus on general mental health rather than suicide. Despite these efforts, the national suicide rate has increased²³. Determining exemplar suicide prevention strategies represents a critical step for planning future action.

Research evidence demonstrates significant limitations in research design, hindering the ability to clarify causal relationships between an intervention

and subsequent effects^{24–28}. Increases in literacy, decreases in stigma, increases in help-seeking intentions or campaign reach are often used to denote effect; however, data on behavioural change are extremely limited. Many campaigns are delivered as one part of larger suicide prevention initiatives, making it difficult to attribute effect to a particular component.

Evaluation data is unavailable for many awareness campaigns and large trials incorporating awareness raising.

Potential harms of awareness campaigns must be weighed against the benefits. It is important to consider the different impacts on diverse populations. In some cases, campaigns have been associated with a reduction in positive attitudes towards help-seeking in particular populations, e.g. depressed adolescents and in certain regions^{29–31}.

Although there is mixed and limited evidence on efficacy, critical elements are required to enhance the effectiveness of awareness campaigns. These features include community engagement, the respectful incorporation of lived experiences, an explicit call-to-action, positioning awareness campaigns as one component of a multi-faceted approach, high exposure (both message reach and duration), active rather than passive platforms, a long-term strategy, consistent and sustained messaging, as well as support service augmentation^{32–42}.

Awareness campaigns may be useful but are not sufficient as a suicide prevention strategy.

Chapter 4: Needs driven, community integrated and data informed: next steps for suicide prevention

The future directions for suicide prevention research and innovation are rarely systematically examined or prioritised. Funding for suicide prevention activities is often shaped by NHMRC or MRFF bids or by the priorities of individual foundations and researchers. How can we better plan, co-ordinate and implement innovation in suicide prevention? What do individuals in the field consider are our best bets for breakthrough and accelerated progress over the next 10 years? Chapter 4 responds to these questions via a survey of individuals from Australia and across the world who are involved across the spectrum of suicide prevention. The aim was to identify the new treatments, technologies, service models or ways of working with the greatest potential to benefit suicide prevention outcomes within a 10-year timeframe.

Individuals need to be actively involved in their own treatment plans and care decisions.

Emerging innovations that may be ready for adoption and wide-scale implementation within five years were also deemed important. These include real-time data registers of suicide and self-harm, including establishment of the National Suicide and Self-Harm Monitoring system supported by a \$15M Federal Government investment in the Australian Institute of Health and Welfare and the National Mental Health Commission⁴³. Integrated systems that link data from different sectors were also considered.

They were viewed as innovative examples of how intersectoral approaches can clarify the ways that individuals and their families traverse different services at different times, what is (un)helpful, and how to ultimately reduce suicide.

Geospatial mapping of incidents allows the identification of suicide clusters and hotspots, allowing targeted local preventative measures to be implemented.

In addition to data innovations, community-based integrated services that consider broader social factors were also recommended, including peer-based aftercare models.

There is emerging evidence for peer-based after-care models for recovery after a suicide attempt.

Although emerging innovations that reflect current priorities were also noted, there is limited support to develop and evaluate these, resulting in lost opportunities to address unmet challenges in suicide prevention. This is illustrated by ketamine, an established anaesthetic drug that causes rapid, clinically relevant reductions in suicidal thoughts when used to treat people with pre-existing mental health conditions⁴⁴. Other emerging innovations include digital or online approaches to improve timely access to appropriate support; distress reduction training for frontline workers; and evidence-based, theory-grounded therapies that focus on psychosocial contributors to suicide risk, such as problem-solving skills or interpersonal relationships. Specific evidence of their outcomes and benefits in suicide is needed.

All chapters highlight the need for greater authentic engagement, co-design and leadership by individuals with lived experience of suicidality and for the voice of Indigenous Australians to be embedded in research, program design, implementation and evaluation.

It is essential to put lived experience of suicidality at the heart of policy and practice.

All chapters also recognise the need for greater investment in a suite of rigorous research methods that balance quantitative and qualitative lines of inquiry—these include (but are not limited to) ethnography, narrative, digital storytelling and other innovative approaches that are well suited to explore lived experience using participatory and co-creative methods. Without the will and actions to invest comprehensively in research, we will continue to spend public money on mass awareness campaigns and on unwanted, unresponsive and, indeed, toxic traditional systems of care.

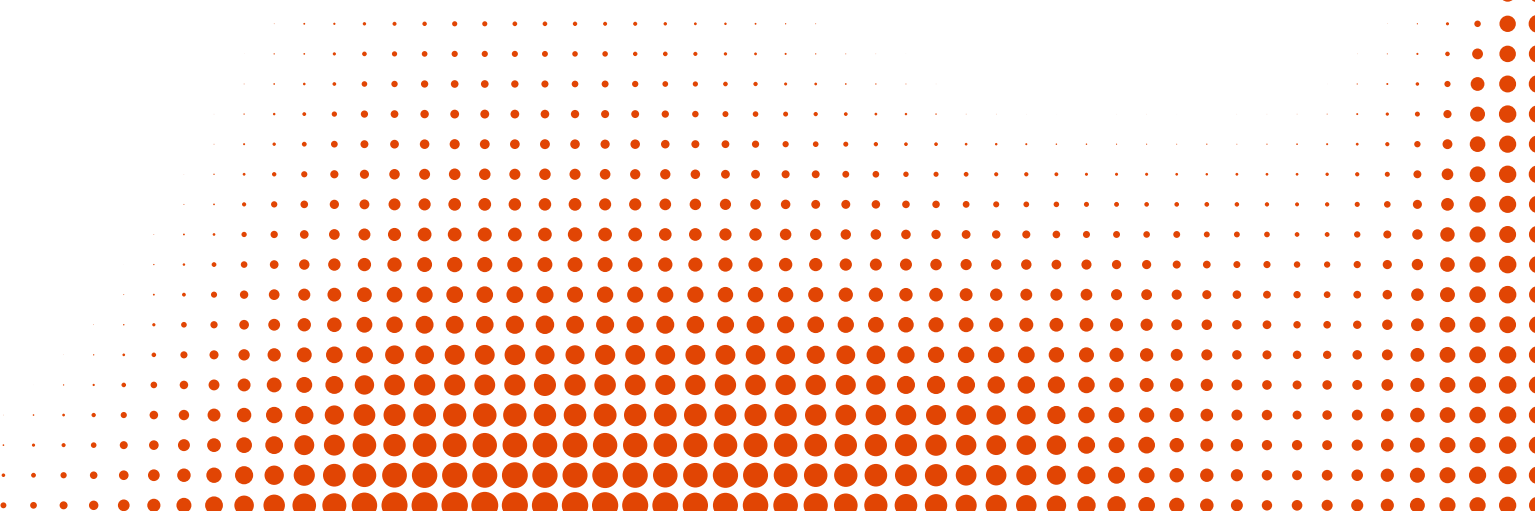
An integrated system with medical and community approaches to care is needed.

The chapters also speak to the need for integration across new and emerging models of suicide prevention with existing services and the aim of reducing, rather than increasing, the complexity of navigating health services. Emerging evidence also supports the use of peer-based aftercare models for recovery after a suicide attempt.

The white paper refines and consolidates our views about new developments in suicide prevention. However, key and surprising insights emerged:

- Innovations in new models of health care must be driven by lived experience and validate the importance of the role of community and peer workers within the Australian health system.
- A person-centred set of needs for care across varying intensity of suicidal crisis was advanced based on personal and lived experience. This insightful description of the phenomenology and emotional overlay of suicidal thoughts is the poster that should hang in every emergency department.
- Digital services, both community and health professional led, were found to be both emerging and high priorities for the future. This means that governments, industry, service users and health professionals need to consider the necessary care and financial models, infrastructure and integration frameworks that are required to build coherent systems to support this fast-paced growth. The challenges of equity of access, digital literacy and engagement must be addressed, along with recognition of the value of user-centred design and an amplified role to co-ordinate and monitor.

- Policy approaches to suicide prevention need to be and can be sharpened with good data and better modelling.
- Suicide prevention mass campaigns must be evaluated using innovative research with real data outcomes including attempts, deaths and self-harm. Governments are required to report the impact of all its initiatives and design data systems so that the entire sector is accountable.
- The views of scientists and researchers in the suicide prevention field describe and frame the direction of the field—best bets are technological, pharmaceutical, data driven and practical—including the immediate priority to review those models co-created and driven by a lived experience perspective.



Summary of Recommendations

Chapter 1 – New models of care

- 1

Embed co-production with people with lived experience of suicide into culturally appropriate design and implementation of models of care, suicide prevention programs and interventions, and research and evaluation.
- 2

Build an integrated systems approach that meets the needs of those experiencing suicidal distress:

 - Fund comprehensive mapping of existing new and emerging services across all modalities. This should go beyond traditional acute and crisis services to include services that meet the needs of people experiencing different intensities of suicidal crisis.
 - Monitor and evaluate all services (existing, new, emerging) attending to person-centred outcomes, implementation processes and outcomes and integration of services.
 - Increase capacity of existing suicide prevention services by prioritising investment in those that show strong evidence of providing person-centred outcomes, can be efficiently scaled, and can demonstrate currently unmet demand.
 - Invest in new or emerging models of care that bridge gaps in the system’s ability to meet the needs of those requiring support; e.g. specific profiles of people, intensity of suicidal crisis, approaches to help-seeker engagement and empowerment.
 - Provide appropriate information regarding access to sources of care for suicidal crisis and ensure well-designed pathways into and out of services. Carefully consider how these services are integrated into the existing suicide prevention system.
- 3

Develop and embed a lived experience workforce for suicide prevention that includes appropriate support structures, professional development and a positive workplace culture, including:

- peer workers
 - academic and non-academic researchers and evaluators
 - leadership and management roles
 - specialists in co-design/co-production, service design and integration, implementation, lived experience and consumer engagement.
- 4

Support capacity building for clinicians, nurses, students, and health professionals who work with suicidal people and educate them about their needs.
- 5

Broaden evaluation of new and traditional services to include research methodologies that move beyond quantification of health/economic benefits and include, for example, qualitative and ethnographic research; long-term, person-centred outcomes; and facilitators and barriers to an integrated system of care. Include the development of a suite of standardised tools to allow for comparison across models of care.

Chapter 2 – Social determinants

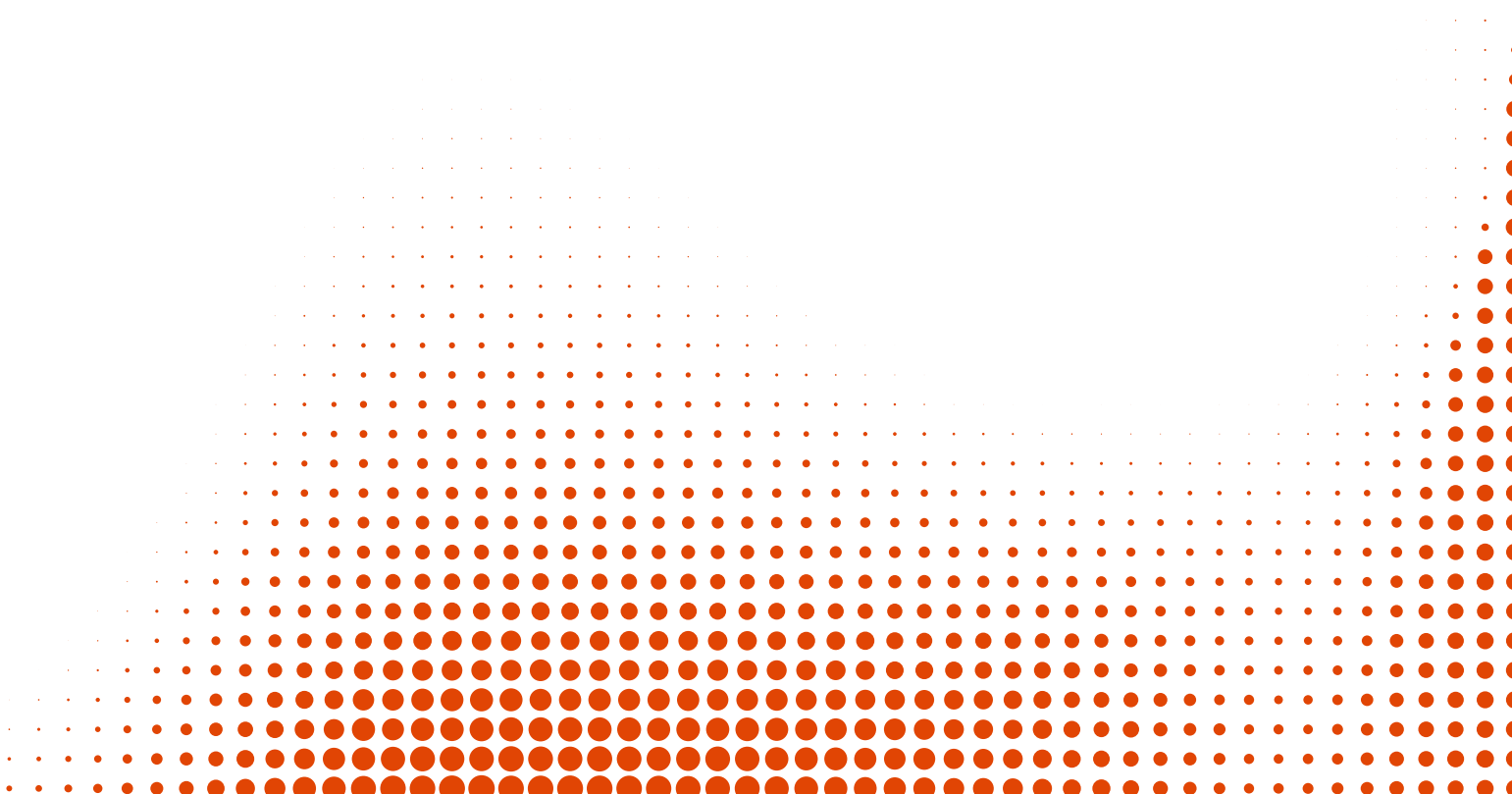
- 1

Incorporate the reduction of poverty, unemployment, homelessness, alcohol use, rural and remote isolation and domestic violence in all suicide prevention strategies and policies. Suicide prevention should also factor into policy and decisions in these other portfolio areas. Explicitly creating these links means creating appropriate whole-of-government structures, cross-portfolio funding and policy mechanisms and ensuring suicide risk and prevention is considered in non-health contexts.
- 2

Ensure the National Suicide Prevention Taskforce considers and advises on the full policy landscape, including non-health components, in its final recommendations to the Prime Minister. We support an ongoing commitment by governments to explore the social determinants of suicide risk from a whole-of-government perspective. Further, we encourage investment in research to identify gaps in the evidence and evaluate the impact of all social and economic policy settings on suicide.
- 3

Invest in data-driven, independently reviewed impact and economic modelling to determine the most impactful and cost-effective policies that can reduce suicide risk at the population level.
- 4

Consider mental health and suicide risk vis-a-vis all policy, regulatory and budget decision-making processes.



Chapter 3 – Awareness campaigns

- 1

Co-ordinate community engagement to tailor appropriate campaigns to high-risk groups.
- 2

Include lived experience and diverse populations in campaign design from their outset and throughout.
- 3

Ensure all campaigns include an evaluation to determine their effect across a range of measures (help-seeking attitudes and help-seeking behaviours, lowered suicide attempts and suicide). These should include longer-term outcomes and the use of strong research design along with impacts on subgroups.
- 4

Investment in research to understand the effect of campaigns as a whole and individual components and mechanisms of action.
- 5

Invest in and promote campaigns that go beyond awareness raising and include components that are likely to have a positive impact on behaviour change.
- 6

Embed effective campaigns within multicomponent suicide prevention strategies that incorporate service-level augmentation at the state and community level.

Chapter 4 – Next steps for suicide prevention

- 1

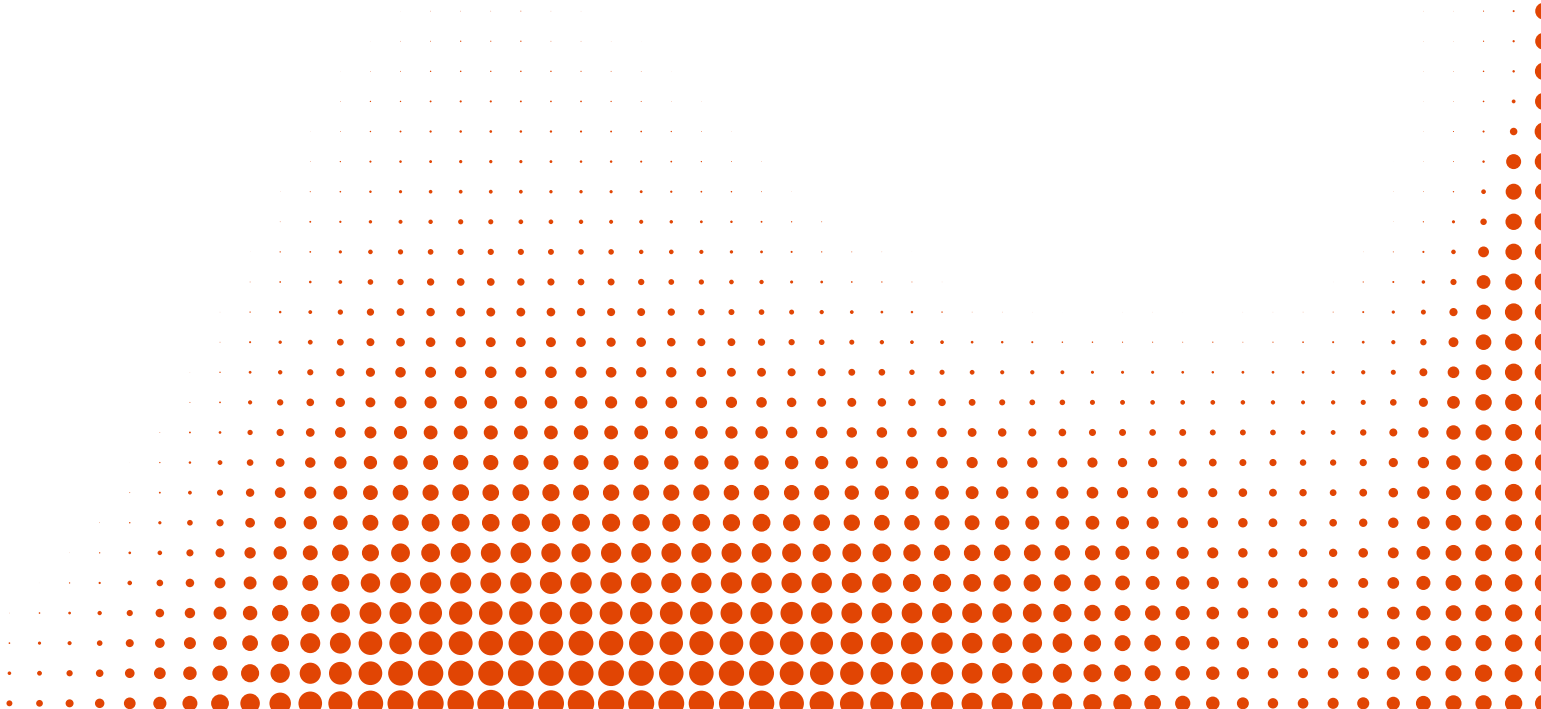
Accelerate the scale-up of evidence-based, non-clinical programmes, such as psychosocial aftercare, brief contact interventions and safe spaces, that address key gaps in the availability of services and support options for different levels of suicidality.
- 2

Embed the active involvement of people in their own treatment plans and care decisions as a guiding principle for all suicide prevention services.
- 3

Establish a clear roadmap, building on current state-level and federal initiatives, for the use of real-time, multi-sector and multi-source data in suicide prevention.
- 4

Support the professional development and integration of the suicide prevention peer workforce into suicide prevention services, recognising their emerging role in suicide prevention and aftercare services.
- 5

Work with Suicide Prevention Australia, the NHMRC, the MRFF and the National Mental Health Commission to establish a strategic, long-term/recurring ‘innovation-to-implementation’ funding stream for the most promising approaches to suicide prevention.



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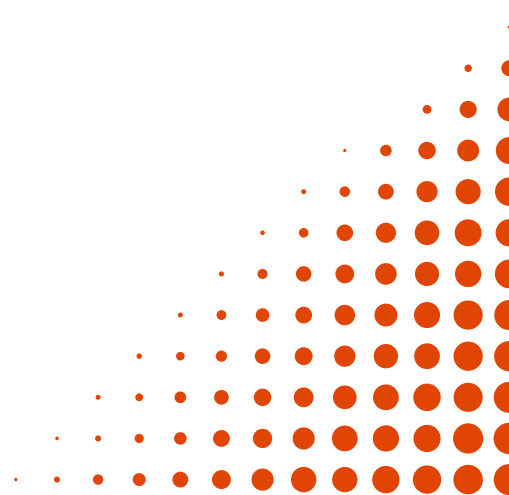
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Meeting the needs of those in suicidal crisis with new models and integrated care

J. Riley, K. Mok, M. Larsen, K. Boydell, H. Christensen, F. Shand

We have a mental health system that struggles to provide care to people experiencing suicidal crisis. New forms of care are required to meet the needs of each individual. What should these look like? How can we ensure these models are integrated, sustainable and effective?

Introduction

In Australia and elsewhere, new models of care have emerged following the advocacy and action of people with lived experience of suicide who recognise that conventional services—characterised by a biomedical approach—often fail to meet the needs of people experiencing suicidal distress. This chapter provides a description of the nature and experience of suicidal distress, reviews innovative care models that are available or emerging, and presents recommendations for future research and approaches to care that can more effectively support those experiencing suicidal thoughts.

The care and support people need when suicidal

The causes and motivations of suicidality are complex, influenced by age, gender, sexual orientation, socioeconomic status, geography, culture and the intersections between them. Contributors to suicidal crisis can include distal factors such as childhood adversity, family history of suicide or mental illness and previous suicide attempt, as well as proximal factors like physical and mental health problems, discrimination and adverse life events (e.g. interpersonal conflict, relationship breakdown, disrupted community or cultural obligations, unemployment, transient housing, limited finances or legal problems)¹⁻⁴.

Distal risk factors for suicide can increase the likelihood of proximal factors; collectively, they can accumulate over time, becoming sources of significant trauma. The complexity of potential contributors to crisis make it challenging to distil and understand the needs of the individual who is suicidal. Further, suicidal thoughts vary in intensity. Although they can progress in a linear way from low to high intensity, this is not always the case. It is important to understand how mental states and thought processes can differ (Figure 1), and what people might find (un)helpful at particular times, in order to avert crisis.

The causes of and motivations behind suicidality are complex, influenced by age, gender, sexual orientation, socioeconomic status, geography, culture and the intersections between them.

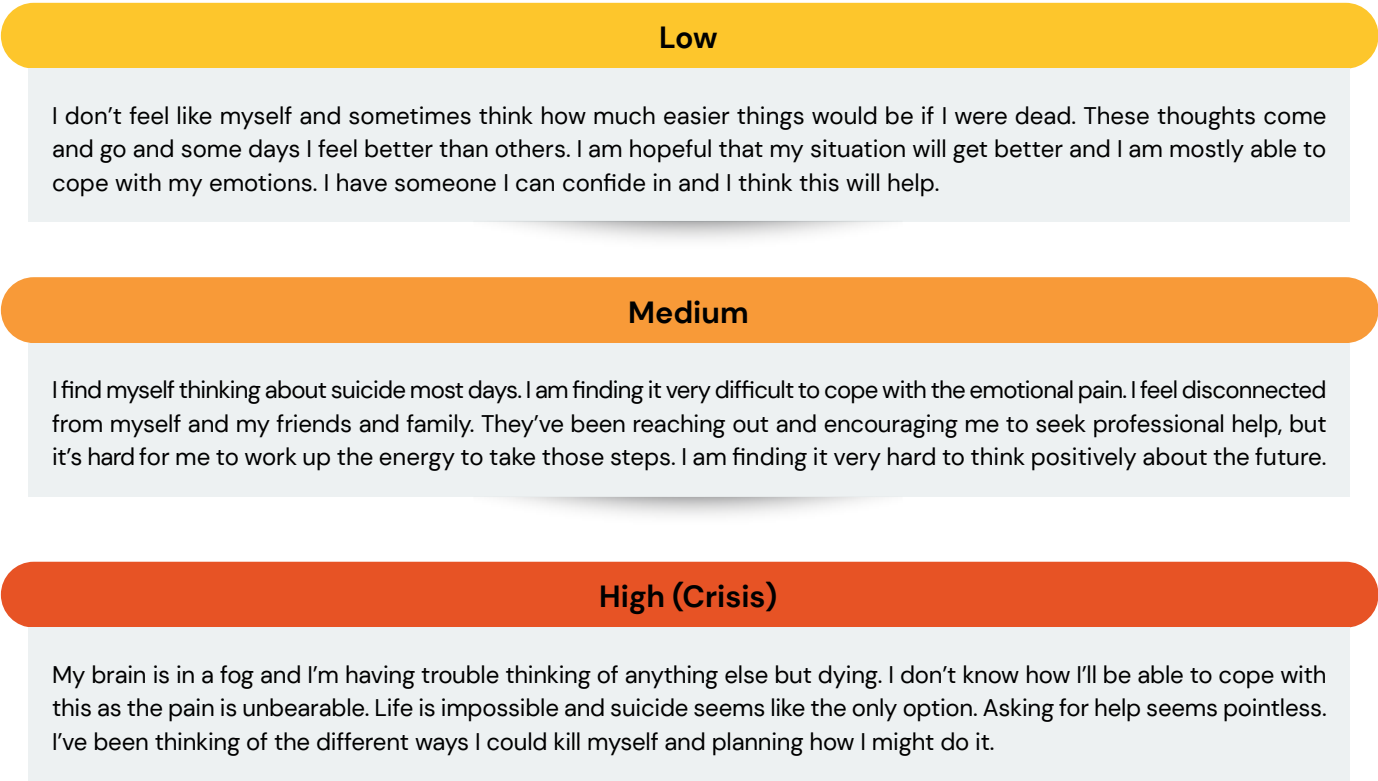


Figure 1. Levels of intensity of suicidal thoughts

Person-centred care needs can influence the intensity of suicidality. The relationships between these needs, as presented in Table 1, were informed by a co-author's lived experience expertise; evidence on the importance of patient engagement and empowerment⁵; and evidence for effective care, which includes comprehensive psychosocial responses from myriad clinical and community services to support the person in their recovery⁶.

Table 1. Person-centred needs based on intensity of suicidal crisis

Category	Person-centred statement of need	Suicidal crisis intensity level*
Physical safety	Provide me with a place where I feel safe while my suicidal thoughts are intense.	High
	Limit my access to ways of physically harming myself.	High
	Tend to my immediate medical needs.	High
	Help me change or manage those things in my life that threaten my physical safety (e.g. alcohol/substance use, exposure to violence, homelessness, etc).	Low-Medium
Psycho-social safety	Support me to stabilise the intensity of my distress.	High
	Treat me with respect and dignity.	All
	Empower me to have autonomy and agency in decisions about my care.	All
	Recognise what has happened to me, how my past traumas may contribute to my current state, and my vulnerability to new trauma while in this state.	All
	Recognise, understand and support my holistic self, including my strengths, culture, religious/spiritual beliefs, identity, relationships, and physical health.	All
Emotional	Listen to me.	All
	Recognise and validate my emotional pain. Help me to do the same.	All
	Help me learn or remember ways other than suicide to cope with my feelings.	Low-Medium
	Help me to move towards a life I want to live by supporting me to clarify my values and what a meaningful life looks like to me.	Low-Medium
Social	Help me build a sense of connectedness with others ...	
	With my trusted support people.	All
	Help my trusted support people to understand the situation and cope with their own needs.	Medium-High
	With new people and places that can help me meet my needs.	Low-Medium
	With community.	Low
Practical	Recognise what has happened to me and help me find solutions to challenges in my life, be it housing, relationships, financial stress, employment, alcohol/ substance use, violence, and so on.	Low-Medium
	All my energy and capacity need to be reserved for my recovery, so make this as easy as possible for me and help me navigate complex systems and processes.	All
Choice, timing and access	Meet my needs at a time and place that fits with how I am feeling and where I am located.	All
	Provide me with options and information about the relative strengths and risks of these options.	All
	Empower me to choose the right supports to meet my own needs and to self-advocate for the care I choose.	All
	Support my human rights. Empower me to self-advocate for these and to choose a trusted support person to advocate for me when I am unable to do so.	All
	Follow up with me and offer to ‘walk with me’ on this part of my journey. If there was a simple and quick solution to the challenges I am experiencing, I would have found it myself. Help me while I need help.	All

*Refers to the level of intensity of suicidal crisis.

A health system struggling to provide care

People experiencing suicidal distress seldom seek help from mainstream services, if at all. Those who do have noted long wait times, being turned away from services, dismissive or harmful attitudes or behaviours among staff, confusing and poorly integrated systems and services, limited (if any) follow up, limited (if any) opportunity to decide the care they receive, and services that are inadequate for people with complex mental health issues or comorbidities⁷⁻¹².

These issues are familiar to many Australians who have accessed (mental) health services while in distress. Although some can be addressed more readily (e.g. training staff to offer better and more sensitive care), many have persisted for several decades, necessitating large-scale policy and structural changes. Governments across Australia have invested in new care models to address these longstanding issues.

Innovative models of care

Innovative care models include those that integrate clinical and non-clinical services across the primary, secondary and tertiary levels of care (see Table 2). Although much is known about traditional clinical approaches^{6,13-15}, we know much less about these innovative models. In this section, we highlight selected examples.

Joint responses to distress and crisis in the community by frontline services

Emergency and frontline services are often the first point of contact for help-seekers. The quality of this interaction can influence whether, how and when help-seekers access support. To improve initial responses to people in crisis, some models co-ordinate clinical, frontline and/or community services. As part of Scotland’s Distress Brief Intervention, trained frontline health care, police,

paramedic, and primary care staff support people in distress, referring them to further support if needed. Following this, trained staff who are affiliated with commissioned not-for-profit organisations contact the person within 24 hours of referral and provide community-based support. An interim evaluation found that people who received this intervention felt that they were treated with compassion, their distress levels decreased and the support might have prevented suicidal behaviour¹⁶.

Although much is known about traditional clinical approaches, we know much less about these innovative models.

In Australia, the Police, Ambulance and Clinical Early Response (PACER) model is a dedicated joint crisis response from police and mental health clinicians. Activated by police, the clinician supports a rapid response to police and ambulance requests for consultation and mental health assessment. By providing an individual in distress with earlier intervention, this model can help to ensure they receive opportune support without restriction of liberty, and with access to a streamlined pathway to mental health services, if required. The evaluation of PACER in Victoria showed that the program resulted in more timely access to mental health assessment, greater use of ambulance services rather than police when transport was required, and fewer referrals to emergency departments¹⁷.

‘...When people are unwell they often fear police, but this program (PACER) has helped to build bridges.’

Spokesperson for Lantern, a support service for the disadvantaged and mentally ill (Department of Health, 2012)¹⁷

Alternatives to emergency departments

Alternatives to emergency departments are designed to provide people in crisis with temporary practical and/or emotional support in a non-clinical setting, such as safe haven cafes or respite spaces. These are often staffed by trained peer workers or volunteers, some with their own lived experience of mental illness and/or suicidality, who sit with visitors to discuss their feelings. These services vary by setting (community vs clinically based), referral pathways, staffing and operating hours¹⁸. Evidence suggests these alternatives to emergency departments can meet the needs of some individuals experiencing high-intensity suicidal crisis¹⁹.

They can also reduce the burden on existing services and reduce mental-health-related ambulance and police callouts²⁰. An independent cost-effectiveness analysis found that the Melbourne Safe Haven café saved over \$30,000 in emergency department costs per year by redirecting people in crisis away from the ED²¹.

Telephone, online communities, digital interventions and digital services

Telephone services such as Lifeline continue to provide social connection and crisis support²². They are now increasingly offering additional support pathways through online chat and text-based crisis support, with promising results^{23,24}. Peer warm line models, where those with lived experience answer calls, reflects community demand for telephone-based support (e.g. Being in NSW, Lived Experience Telephone Support Service in SA).

The range of online communities include informal user-driven online groups (e.g. Reddit) and digital services moderated by trained volunteers, peer workers or professionals (e.g. Big White Wall, Koko, SANE Australia, Beyond Blue). Although online communities can facilitate stigma-free social connections²⁵ and are accessed by individuals experiencing thoughts of suicide, there is limited evidence on whether and how they reduce suicidal thoughts or promote wellbeing.

Digital interventions, which are internet-delivered programs usually developed by academics, include brief aftercare interventions using automated text messaging apps such as Reconnecting AFTer Discharge (RAFT)²⁶, digitally delivered supportive messages from a person's clinical care team²⁷, safety planning apps (e.g. BeyondNow), and interventions

to reduce the risk of suicide (e.g. LWST²⁸). Digital interventions directly targeting suicide rather than related issues (e.g. depression) can reduce suicidal ideation²⁹. Telephone, internet and digital interventions can provide scale and reach. They might also be the preferred conduit to care among individuals who feel they are less stigmatising or prefer to avoid face-to-face contact. They can also be integrated with, or provide a supplement to, face-to-face care. Standalone digital services, such as Ginger.io in the United States, offer promising new directions as they provide mental health support and clinical care directly to those with suicide crises who approach them

through their digital portal. TEN – The Essential Network for health professionals (<https://www.blackdoginstitute.org.au/ten/>) and MOST Moderated Online Social Therapy for Youth Mental Health (<http://most.org.au/>) are early models emerging in Australia.

Digital services, both community and health professional led, are at a tipping point. Given their popularity and effectiveness, governments, industry, service users and health professionals all need to consider the necessary care and financial models, infrastructure and integration frameworks that will build coherent and mature systems to support this inevitable growth.

Integrated services

Although it is important to ensure that a first point of contact is helpful, it is equally important to ensure follow-up care that is equally helpful. New services must be integrated with existing services and should aim to reduce rather than increase the complexity of navigating health services. A better understanding of how to connect current and innovative services to optimise quality care is needed.

Evaluations of recently established aftercare services in Australia (e.g. The Way Back Support Service, SP Connect, Next Steps) suggest that consumers' mental health needs are only a subset of their broad needs³⁰. Using care co-ordinators, these services integrate the different services a person requires to support their recovery. The need for integration was highlighted by an evaluation of Place of Calm, a respite centre in the United Kingdom. While service users valued the normalising and engaging environment of

peer-led support, they feared leaving the centre, concerned about how their long-term needs would be met³¹. Integrated care must therefore also involve community and cultural services that support people's social and welfare needs (e.g. relationship breakdown, homelessness, unemployment, legal problems), which can precede suicidal behaviour. Successful integration between and within primary, secondary and tertiary levels of care will help to ensure people can access the support they need and want at preferred times, thereby averting crisis.

Alternatives to emergency departments are designed to provide people in crisis with temporary practical and/or emotional support in a non-clinical setting.

The need for evaluation

As new models of care emerge, rigorous mixed-methods evaluations—co-created with people with lived experience—are required to determine their feasibility, acceptability, implementation processes and effectiveness.

As we broaden care beyond the clinical setting, researchers must balance traditional research designs (which rely heavily, if not solely, on quantitative data) with those that helpfully capture what matters most to people with lived experience—(prospective) consumers, (prospective) carers, clinicians or service managers. Qualitative methodologies are better suited to understanding the help-seeker's experience, perspectives, needs and quality of life. Many have co-creation and empowerment principles embedded within their methodologies^{32,33}. Additionally, adoption of best practice cultural governance and acknowledgment of Aboriginal and Torres Strait Islander holistic research and evaluation models and frameworks is necessary to ensure models of care encompass Indigenous needs and are culturally safe.

Key research questions to achieve an integrated and needs-driven system of care:

- How might newer services (e.g. safe haven cafes) integrate with existing services (e.g. emergency departments, primary care, telephone, internet or digital offerings) to contribute to an individual's recovery and healing over the short and long term?
- Do help-seekers interact with an array of services or sources of support (e.g. family, informal peer relationships)? What are the differential and cumulative effects of service or support contacts? How does integration of services and ease of system navigation influence this outcome?
- Are some models of care (or combinations of integrated models) better suited to the needs of certain help-seeker profiles? How do we connect help-seekers with the services that are most likely to match their needs? Which groups are missing out or 'under the radar' and what do they need?
- How can telephone, internet and digital models offer an alternative to, supplement or integrate with face-to-face models of care? How can help-seekers and professionals be supported to find and select effective virtual supports?
- How do we adapt and implement a model of care that has shown promise elsewhere with a different population group or in a different modality (e.g. face-to-face versus digital)?
- Where are people being supported for suicidal crisis outside of the traditional suicide prevention field or health system; e.g. in homeless shelters, women's refuges, drug/alcohol services, or other community-based organisations? What can be learned from such places? How can these services be integrated into a more holistic view of suicide prevention support services?
- What investment is needed to develop workforce competency, capacity and culture, including the emerging suicide prevention peer workforce, to ensure the needs of those experiencing suicidal crisis are fulfilled?

As we broaden care beyond the clinical setting, researchers must balance traditional research designs with those that helpfully capture what matters most to people.

Recommendations

1

Embed co-production with people with lived experience of suicide into culturally appropriate design and implementation of models of care, suicide prevention programs and interventions, and research and evaluation.

2

Build an integrated systems approach that meets the needs of those experiencing suicidal distress:

- Fund comprehensive mapping of existing new and emerging services across all modalities. This should go beyond traditional acute and crisis services to include services that meet the needs of people experiencing different intensities of suicidal crisis.
- Monitor and evaluate all services (existing, new, emerging) attending to person-centred outcomes, implementation processes and outcomes and integration of services.
- Increase capacity of existing suicide prevention services by prioritising investment in those that show strong evidence of providing person-centred outcomes, can be efficiently scaled, and can demonstrate currently unmet demand.
- Invest in new or emerging models of care that bridge gaps in the system's ability to meet the needs of those requiring support; e.g. specific profiles of people, intensity of suicidal crisis, approaches to help-seeker engagement and empowerment.
- Provide appropriate information regarding access to sources of care for suicidal crisis and ensure well-designed pathways into and out of services. Carefully consider how these services are integrated into the existing suicide prevention system.

3

Develop and embed a lived experience workforce for suicide prevention that includes appropriate support structures, professional development and a positive workplace culture, including:

- peer workers
- academic and non-academic researchers and evaluators
- leadership and management roles
- specialists in co-design/co-production, service design and integration, implementation, lived experience and consumer engagement.

4

Support capacity building for clinicians, nurses, students, and health professionals who work with suicidal people and educate them about their needs.

5

Broaden evaluation of new and traditional services to include research methodologies that move beyond quantification of health/economic benefits and include, for example, qualitative and ethnographic research; long-term, person-centred outcomes; and facilitators and barriers to an integrated system of care. Include the development of a suite of standardised tools to allow for comparison across models of care.

Table 2. Mapping of existing and emerging approaches to care based on intensity of suicidal crisis

	Suicidal crisis intensity level			
	Low/early	Medium	High/crisis	Recovery
Clinical	Face-to-face/digital psychological treatment (e.g. CBT, DBT) Blended digital programs (e.g. THIS WAY UP, Mindspot) Medication Digital-first mental health services (e.g. Ginger.io, TEN, MOST)		Clinical crisis services (e.g. ED, crisis response teams) Specialist clinical support for suicide in community/ non-clinical settings (e.g. James’ Place, UK, Pieta House, Ireland, AISRAP Life Promotion Clinic)	Psychological care to address long standing issues
Self-help, non-clinical and crisis models	Digital self-management/ self-help (e.g. iBobbly, Living with Deadly Thoughts)	Frontline, clinical and community responses (e.g. Scotland’s Distress Brief Intervention, Australia’s PACER model)		Face-to-face/digital aftercare services (e.g. Way Back Support Service, SP connect, Next Steps, RAFT)
			Integrated suicide prevention centres with crisis lines/internet interventions (e.g. Amsterdam’s 113) Alternative to ED waiting rooms (e.g. Safe Haven Café Melbourne, Living Edge Brisbane) Respite spaces (e.g. Maytree) Suicide prevention outreach teams ED to home transition programs (e.g. Peer2Peer WA)	
Community	Telephone, internet, digital support (e.g. chatlines, helplines, Koko) Face-to-face/digital support groups (e.g. DISCHARGED, Alternatives to Suicide, Lifeline Eclipse groups)			
	Face-to-face/digital safety planning (e.g. BeyondNow)			
	Organisation-moderated online forums (e.g. beyondblue) Arts-based approaches (e.g. drawing, journaling, arts engagement programs e.g. Culture Dose)			
			Peer-run respite spaces (e.g. Western Mass RLC Afiya House, Place of Calm) Peer-run safe spaces (e.g. safe haven cafes UK, Brisbane North safe spaces with sensory rooms)	

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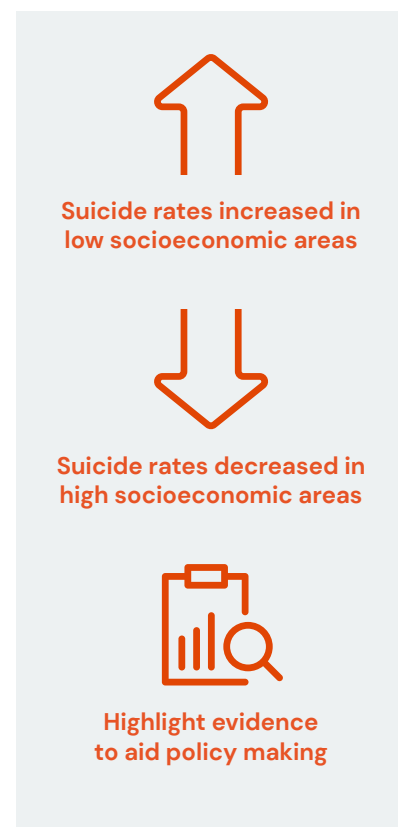
The impact of social determinants on suicide and how policy settings can help

F. Shand, D. Yip, M. Tye, L. Darwin

Suicidal behaviours are shaped by the social, economic and physical environments in which we live, otherwise known as the social determinants of health and wellbeing. Governments in Australia can change policy to reduce suicide rates. What policies have proven value? What do we need to know in order to prioritise and implement them?

Introduction

Suicidal behaviours are shaped by the social, economic and physical environments in which we live, otherwise known as the social determinants of health and wellbeing. Understanding how social determinants impact suicide is necessary to informing the development of, or improvements to, policy and practices that can redress social inequalities and prevent suicide at a population level.



Social determinants across the life course play a critical role in the development of mental illness¹ and have a similar impact on rates of suicide. This is reflected in recent findings that suicide rates in Australia have increased in areas of low socioeconomic status and declined in areas of high socioeconomic status². Here, we provide an overview of the social determinants and associated government policies that have a demonstrable impact on suicide rates. Rather than making specific policy recommendations, we aim to highlight the evidence for a range of policy areas, identify gaps in the evidence, and make recommendations regarding how the evidence can be considered in policymaking and contribute to ongoing policy via the Suicide Prevention Taskforce.

¹Our focus is on country-level factors, which might affect community, service, and family factors; however, these are not what we are reviewing.

Understanding how social determinants impact suicide is necessary to informing the development of, or improvements to, policy and practices that can redress social inequalities and prevent suicide at a population level.

Background to suicide prevention in Australia

Recently, there has been significant investment from federal and state governments in evidence-based suicide prevention practices. Specifically, the investment has been in multi-level prevention approaches where regional suicide prevention alliances guide the simultaneous implementation of several evidence-based strategies (e.g. community training, school-based programs, improved media reporting of suicide, means restriction and improved crisis response).

The evidence for these multi-level, multi-sectoral models is derived from the European Alliance Against Depression (EAAD) model. The EAAD has the strongest evidence of effectiveness in reducing suicidal behaviour³ based on research in Europe, with some evidence to support a multi-level model in Japan (in rural but not urban settings)⁴. The impact of Black Dog Institute's LifeSpan integrated suicide prevention framework and other multi-level models of suicide prevention in Australia are not yet known; however, an international review of all evidence for suicide

prevention concluded that '...no single strategy clearly stands above the others. Combinations of evidence-based strategies at the individual level and the population level should be assessed with robust research designs⁵. In Australia, this work has covered many regions and has resulted in a substantial shift in the way suicide prevention work is planned and carried out. Nevertheless, none of these models purport to prevent all suicides. While each of these models, if implemented well and with enough reach and dose, is likely to prevent a substantial proportion of suicides, more is

required if we are to prevent the maximum number of suicides.

'To create a genuinely effective, sustainable approach to suicide prevention, we need to have the hard conversations, to really look at how we live, how we communicate, and how we treat others, especially those who are vulnerable, and how our various systems—health, social, welfare, economic, education, and others—exacerbate or contribute to suicide.'

Black Dog Institute, Crisis and Aftercare Lived Experience Group 2020: Mok et al., Rapid Review for the National Suicide Prevention Task Force

Building on Australia’s suicide prevention work

It is a sensible next step to build on the momentum created by the Australian place-based suicide prevention trials. While regional approaches to suicide prevention are an important part of suicide prevention efforts, they have not substantially addressed the role of social determinants in suicide.

These evidence-based practices must be supported by policy settings that focus on improving the social conditions in which people live so that regional, state and national strategies are working hand-in-hand. Understanding what, how, and which features of policy might reduce suicide risk is particularly important in Australia now: the National Suicide Prevention Taskforce (NSPT) is currently advising the government to consider a wide variety of policy responses to suicide and to build mental health and suicide prevention into their policy

decisions. This has occurred to some extent already with the response to the COVID-19 pandemic in the form of higher welfare payments, employee payments, and tax relief measures. There are well established socio-environmental factors that shape suicide risk, such as poverty, unemployment, homelessness and domestic violence⁶⁻¹⁰. The suicide rates among unemployed men are particularly evident¹¹. Geographical location is also linked with suicide rates¹². People living in rural and remote areas have a higher suicide risk

compared to those residing in metropolitan areas. Men are at particular risk, which may be explained by cultural factors such as stoicism, social disadvantage, limited access to health services, access to means and capability, and limited access to job opportunities^{13,14}. Similarly, homelessness is associated with elevated suicide risk, with the majority of people who are homeless reporting suicidal ideation and attempts¹⁵. Intimate partner violence is a strong risk factor for suicide attempts and ideation in women¹⁶⁻¹⁸.

While regional approaches to suicide prevention are ... important, they have not substantially addressed the role of social determinants in suicide.

Evidence for the influence of policy on suicide

The social context of these risks means that governments have available to them a range of policy levers that can influence outcomes at a population level by addressing social inequalities. There is evidence that health, economic and social policy areas can impact suicide outcomes.

A search of the scientific literature by the Black Dog Institute has identified several policy areas where there is at least one study demonstrating a link with suicide: unemployment and welfare support policies^{19,20}, improving access to treatment for mental illness^{21,22}, alcohol pricing and availability policy²³, reducing access to the means

of suicide^{24,25}, justice and detention policies²⁶, LGBTQI+ marriage equality legislation²⁷, and austerity solutions to economic downturn (which put upwards pressure on suicide rates)²⁸. Large studies of welfare support and suicide show that countries with more generous welfare payments and active labour market programs

experience little or no increase in suicide during economic downturns, whereas countries with less generous welfare see substantial increases in suicide^{29,30}. Alcohol policy has a well-established impact on suicide, with lower availability, higher price, and older legal drinking age linked with lower rates of suicide³¹.

Governments have available to them a range of policy levers ... there is evidence that health, economic and social policy areas can impact suicide outcomes.

Gaps in the evidence

What is not yet clear is which policies and policy settings are likely to be the most impactful and cost-effective in the context of reducing suicide risk.

This chapter identifies the broad range of policy areas or targets that might be considered. There needs to be consideration of mental health and suicide risk consequences of policy and budget decisions at state and federal government levels. Evidence for each policy area should be systematically

reviewed and synthesised and gaps identified. Available evidence can be used to model the impact of different policy settings on suicide outcomes. While the focus of this chapter is on policies that have demonstrated impact on suicide outcomes, there are other social determinants of

mental health and suicide which, while there is no policy research to draw upon, have a relationship with suicide. One clear example of this is geographical location. While this is a social determinant of suicide outcomes, we have not been able to identify studies of policies that might address this.

Current policy in Australia

As discussed earlier in the context of multi-level suicide trials, Australia has already adopted what might broadly be termed, universal prevention strategies, that directly or indirectly target suicide.

Strong media guidelines on reporting suicide is an example of a strategy that has directly targeted suicide prevention. There is a significant evidence base demonstrating that media reporting of suicides is linked to an increase in suicide³²⁻³⁵, which is frequently referred to as copycat behaviour or as the Werther effect³⁶. For instance, following the suicide of comedian and actor Robin Williams in 2014, there was a 10% increase in suicides in the US amongst men slightly younger than Williams (who would have grown up watching him) in the two months after his death³⁷. A more recent example is Netflix's '13 Reasons Why'. During the three months after its release in 2017, there was an increase in suicides among 10- to 19-year-old adolescents and young adults, especially amongst young women (22% increase compared to 12% increase in men) whose ages were similar to the character who died by suicide in the series³⁸.

In Australia, the Mindframe National Media Initiative (Mindframe) engages in various activities, including releasing guidelines, creating resources and running workshops for media and non-media professionals to ensure responsible portrayals and communication about both fictional and non-fictional suicides (see <https://mindframe.org.au/>).

Other strategies have been directed at reducing other harms but may have indirectly helped to prevent some suicides. This is the case with means restriction; e.g. stronger gun control legislation and the introduction of catalytic converters for pollution control³⁹, and medication strategies aimed at reducing both intentional and unintentional self-poisoning. Maintenance of strong gun control legislation is sensible, particularly when given the relationship between population rates of gun ownership and gun-related suicides⁴⁰.

While these strategies are welcome, a more targeted approach could be adopted by reviewing the existing evidence for the full range of policies with regards to their impact on suicide, investing in new research to evaluate the impact of specific policy changes, investing in impact and economic modelling to determine which policies and policy settings have the greatest potential to reduce suicide risk and under which conditions, and incorporating mental health and suicide risk impacts in policy decision-making processes. National system dynamics modelling in this area is progressing in Australia⁴¹ and internationally⁴². Recommendations have emerged from the modelling work at the Brain and Mind Centre, University of Sydney, to reduce suicide risk resulting from the pandemic: maintain JobKeeper payments to reduce financial uncertainty, provide further education support for young people,

“A more targeted approach could be adopted by reviewing the existing evidence ... investing in new research ... investing in impact and economic modelling ... and incorporating ... mental health and suicide risk impacts in policy decision-making processes.”

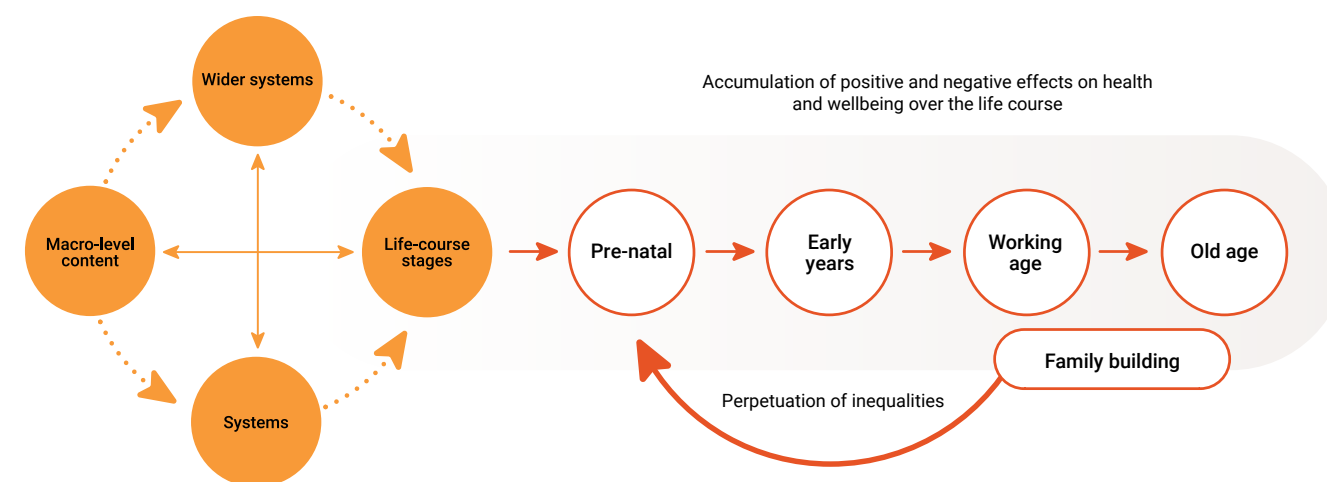


Figure 1: A life course approach to tackling inequalities in health, adapted from WHO European Review of Social Determinants of Health and the Health Divide (1)

reduce social dislocation by minimising the spread of the virus, and increase real health service capacity, especially for those with more complex disorders⁴¹. This work could be expanded by building a stronger evidence base for policies as suggested above, and guided by the life course framework laid out by the World Health Organisation. This framework allows one to address policies that impact social determinants from the pre-natal phase through to older age (Figure 1), which demonstrates the cumulative effects of social

determinants across the life span. What is needed is a process for considering health and suicide impacts of government policies. Research conducted on behalf of Suicide Prevention Australia found that 71% of Australians want all government decisions to consider the risk of suicide and have clear plans in place to mitigate any negative impacts following from those decisions⁴³. This could involve changes to cabinet and budget expenditure processes to ensure review of potential impacts and development of mitigation strategies.

Conclusion

Place-based, multi-level models of suicide prevention are likely to reduce suicide rates if implemented at scale and depth; however, they must be supported by policies that address social determinants in order to improve suicide prevention.

Social determinants such as poverty, unemployment, homelessness, alcohol use and domestic violence are risk factors for suicide; their amelioration will lead to decreased suicide rates. A range of federal

and state government policies can influence suicide rates, but what is not clear is which policy levers are likely to have the highest impact and to be most cost-effective.

“Place-based, multi-level models of suicide prevention are likely to reduce suicide rates if implemented at scale and depth.”

Recommendations

There are substantial barriers to addressing the social determinants of health, including the reality that evidence is only one of many influences on policy decisions. There are gaps in our knowledge about how government policies can influence suicide risk. For evidence to be reflected within government policies, it must be linked to pragmatic solutions, strategies and outcomes that can be delivered within government⁴⁴.

- 1

Incorporate the reduction of poverty, unemployment, homelessness, alcohol use, rural and remote isolation and domestic violence in all suicide prevention strategies and policies. Suicide prevention should also factor into policy and decisions in these other portfolio areas. Explicitly creating these links means creating appropriate whole-of-government structures, cross-portfolio funding and policy mechanisms and ensuring suicide risk and prevention is considered in non-health contexts.
- 2

Ensure the National Suicide Prevention Taskforce considers and advises on the full policy landscape, including non-health components, in its final recommendations to the Prime Minister. We support an ongoing commitment by governments to explore the social determinants of suicide risk from a whole-of-government perspective. Further, we encourage investment in research to identify gaps in the evidence and evaluate the impact of all social and economic policy settings on suicide.
- 3

Invest in data-driven, independently reviewed impact and economic modelling to determine the most impactful and cost-effective policies that can reduce suicide risk at the population level.
- 4

Consider mental health and suicide risk vis-a-vis all policy, regulatory and budget decision-making processes.

There are substantial barriers to addressing the social determinants of health, including the reality that evidence is only one of many influences on policy decisions.

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3

Suicide awareness campaigns: are they a valid prevention strategy?

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**Suicide prevention public awareness campaigns are growing in popularity, but do they work?
What research evidence do we have to support the efficacy of these campaigns?
What critical elements support effectiveness of awareness campaigns?**

Introduction

Australia’s suicide rate has been trending upwards in the last decade, leading to renewed efforts to prevent suicide.¹ Public awareness campaigns, traditionally delivered through mass media, have become increasingly popular globally to combat these rates.²



Improving responsiveness and literacy



Improving individual help-seeking



Encouraging immediate action in suicidal crisis

- These campaigns tend to focus on:
- improving responsiveness and literacy in the general public to identify and respond appropriately to warning signs and risk factors in self and others;
 - lowering stigma and raising awareness to improve individual help-seeking; and
 - encouraging immediate action by individuals in suicidal crisis.^{3, 4}

In practice, determining a campaign’s specific objective(s) and knowing exactly what classifies as an awareness campaign can be difficult. Campaigns may aim to achieve these objectives directly, incidentally or indirectly, for example, by targeting risk factors. For the purposes of this paper, suicide awareness campaigns are defined as planned, public level information delivered using mass media.

Although suicide awareness campaigns are increasingly widespread, reporting of their efficacy is limited. With the announcement of \$10.4 million for a national awareness campaign due to COVID-19,⁵ it is critical to evaluate whether this is an effective use of funds. Indeed, the question of what even defines effectiveness of such campaigns remains unclear—for example, is the expected outcome population-level behavioural change that prevents the occurrence of attempts and suicides? Or is the outcome something else altogether, attitude change and destigmatisation?

These, and several other issues, require clarification if the design and implementation of future campaigns is to be optimised or recommended above other suicide prevention activities.

The aim of this chapter is to clarify key questions concerning awareness campaigns to determine future investment in these strategies. First, are these campaigns effective (and why)? On what grounds? And in which domains? Second, what are the critical components of successful campaigns? Third, are these components incorporated into recent/ current initiatives? To conclude, we explore policy implications of these considerations.

“The aim of this chapter is to clarify key questions concerning awareness campaigns to determine future investment in these strategies.”

Evidence of effect

Recent reviews have highlighted key findings regarding suicide awareness campaign efficacy.⁶⁻¹⁰ However, much of the available evidence has limitations with respect to causality due to research design and the practical difficulties of mounting gold-standard approaches (e.g. the use of Randomised Controlled Trials (RCTs) in community settings). Additionally, these programs often tend to be delivered as one element of larger suicide prevention initiatives.¹¹

Some campaigns have been shown to improve (albeit modestly) knowledge ¹²⁻¹⁴ and help-seeking intentions. ^{4, 15, 16}	awareness campaign component is, at best, inexact. Only one single ‘standalone’ awareness campaign in Japan has been shown to decrease rates of death by suicide, ²² and it required an intensive and unsustainable amount of resourcing. It is unclear if such strategies would be effective in different cultural contexts.	problems actually reduced, despite this issue being an explicit target of the campaign. It is also important to consider the differential impact on diverse populations.
Generally, these programs are also associated with positive changes in attitudes during or immediately following a campaign. ^{4, 15} However, the impact of these changes on actual behavioural outcomes (e.g. help-seeking) is unclear. ¹⁴	The potential benefits of these campaigns relative to potential harm must also be considered. For instance, Till and colleagues ²³ found a campaign aimed at improving help-seeking via a suicide hotline, did not appear to motivate suicidal individuals to call, and crisis calls for family	For instance, despite consistent findings regarding overall improvement in attitudes, there is some evidence that campaigns may be associated with reduced positive attitudes towards help-seeking in certain sub-populations (e.g. depressed adolescents, ^{24, 25} certain regional populations ²⁶). Mass media campaigns are often expensive, thus money spent on them is unavailable for other mental health or suicide prevention initiatives.
Moreover, studies tend to have insufficient statistical power to examine attempts or deaths as outcomes ^{6, 7} and those that do are generally part of multicomponent programs, ¹⁷⁻²¹ so attributing effect to the		

“Although suicide awareness campaigns are increasingly widespread, reporting of their efficacy is limited... it is critical to evaluate whether [these interventions are] an effective use of funds.”

Critical campaign elements

Given this mixed and limited evidence on efficacy, it is useful to determine the elements, if any, that increase campaign success or failure. Because of lack of RCT evidence, evaluation of these campaign elements is based on largely observational data.

First, there remains a lack of understanding of what makes messages in suicide prevention campaigns safe and effective.²⁷ Recommendations of an expert US-based workshop²⁸ claim that media campaigns must:

- i. adopt a scientific approach throughout;
- ii. pre-test messages;
- iii. consider the impacts on both targeted and non-targeted groups;
- iv. portray helpful options/solutions; and,
- v. not overgeneralise particular risk factors (thereby normalising suicide within groups).

An Australian workshop²⁷ emphasised that campaigns must validate or reflect the target group's issues and needs

and promote help-seeking behaviours. However, this workshop also raised concerns that varied audiences may interpret messages differently, resulting in unfavourable outcomes. As such, careful deliberation, tailoring and testing of message content is critical.

Some evidence indicates that since stigma and poor suicide literacy are associated with reduced intentions to seek help, messages that improve literacy and reduce stigma are important in facilitating help-seeking.²⁹ One study found that the most highly-rated messages by both suicide prevention experts and those with lived experience of suicide were those that encouraged family members or friends to ask directly about suicidal thoughts and intentions, listen to responses without

judgment, and tell the person at-risk that they care and want to help.³⁰

Intensity of exposure and duration of campaigns are also relevant factors. Evidence suggests that where the intensity of the campaign message varied across regions, improvements in help-seeking were only observed where more intense implementation occurred.³¹ Short-term initiatives have very little, if any, effect⁹ and even where knowledge gains have been found, these were generally not maintained over time.^{6, 8} Similarly, insufficient research exists to suggest standalone awareness interventions have any impact on reducing suicide rates or changing suicide behaviours.^{8, 10} Campaigns containing no call to action or support service augmentation are unlikely to change behaviour.⁶

“Much of the available evidence has limitations with respect to causality due to research design and the practical difficulties of mounting gold standard approaches in community settings.”

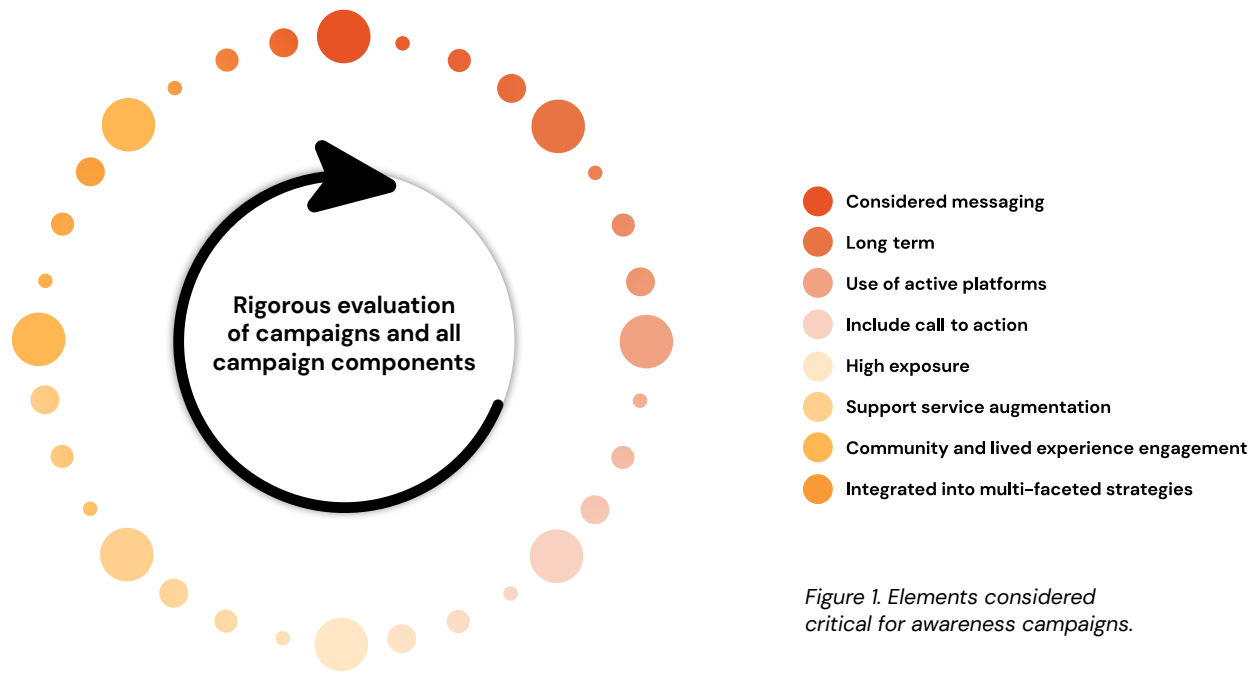


Figure 1. Elements considered critical for awareness campaigns.

Campaigns that rely primarily on ‘passive’ exposure platforms (e.g. billboard advertisements) tend to be the least effective campaigns and in some instances have shown decreases in coping and in intentions to seek help.^{23–25} These platforms may fail to provide information about services, or to imbed the topic of suicide into a broader discussion about wellbeing that is possible via other mediums.¹²

Interestingly, this effect appears to be ameliorated with appropriate crafting and enhanced personal appeal of messaging. Consequently, actively involving different community stakeholders and the

target populations in the design, messaging, and implementation of campaign content is a critical element in campaign success.^{32,33} Similarly, the role of lived experience holds promise, not only in guiding content and delivery but potentially in the delivery of the message itself. For example, it has been shown that utilising lived experience storytelling may be more effective than the testimony of professionals in reducing risk.³⁴

Sustained programs with sufficient exposure (message reach and duration) that involve multiple levels of a society and establish a community support network are most reliably

successful.⁹ Similarly, these campaigns are more likely to be effective when delivered in conjunction with other strategies that produce corresponding improvements in availability of—or access to—relevant support services or training.¹⁸ Awareness campaigns may then be preferably delivered as one component of a multifaceted approach including community training, aftercare services following a suicide attempt, and building the capacity of health professionals and communities to detect and manage suicidality.⁶ These key components are summarised in Figure 1.

“To date, increases in literacy, help-seeking intentions or campaign reach are often used as markers of success, while behavioural outcome data is limited.”

Australian campaigns, past and present

In Australia, the last two decades have witnessed significant national and regional, government and philanthropic initiatives undertaken to prevent suicide. These involve at least some element of awareness campaigning but tend to blend these components with broader suicide prevention strategies or focus on general mental health rather than suicide. Despite these efforts, over the last 15 years, the national suicide rate has increased.³⁵ Determining which prevention strategies form exemplar approaches is crucial to planning future action.

The R U OK? campaign is a highly recognised initiative and one of the few with current evaluation data. It aims to engage the community to ask, listen, and encourage action, and provides resources for all stages of this process. Program evaluations have focussed on awareness of its presence, message, or involvement; or assessed help-seeking/help-provision intent or stigma reduction,^{36–38} with generally positive results.

The recent multicentre collaborative #youcantalk campaign and SANE Australia’s Better Off With You campaign draws on input of individuals with lived experience of suicide. Data from these campaigns are not yet available. Currently, a 12-site, Australia-wide National Suicide Prevention Trial (Life in Mind, 2019), and the Black Dog Institute’s NSW-based LifeSpan program utilise awareness

raising as one element of multicomponent prevention strategies. Findings for these large trials are not yet available.

Specific at-risk groups are often a focus for campaigns due to high suicide rates, high stigma levels or low help-seeking. Targeted populations have included men, rural communities, young people, certain high-risk occupational groups, Indigenous people, refugee populations, culturally and linguistically diverse groups and LGBTQI+ populations. However, with the exception of those aimed at men^{39–44} and young people^{13, 17, 45, 46}, little evaluation data is available on these specific at-risk group campaigns.

There has been some consideration of diversity in recent campaigns. For instance, the Centre of Best Practice in Aboriginal and Torres Strait Islander Suicide Prevention

(CBPATISIP) was a collaborator on the #youcantalk campaign and R U OK?’s Stronger Together campaign. However most Indigenous prevention programs are localised to specific communities or regions (e.g. Wot Na Wot Kine,⁴⁷) and have limited media campaigning or evaluation. The Yarns Heal and subsequent Talking Heals programs (encouraging help-seeking via storytelling) are further examples of targeted campaigns. At a national level MindOUT! promotes and delivers suicide awareness campaigns for LGBTQI+ people and communities. Again, individual program data is not openly available. More work is needed in these at-risk and often marginalised groups, such as refugee, and culturally and linguistically diverse communities who are often neglected where language barriers alone make mainstream campaigns inadequate.

Policy implications

Part of the appeal of mass media awareness campaigns is that they can seemingly reach mass populations with minimal long-term resourcing. They can also be an easier option than interventions aimed at reducing known risks for suicide or improving mental health and support services. However, the costs (and opportunity costs) associated with awareness campaigns can be sizable, both financially and in promoting a perception that something is being done to address suicide.

Evaluation is critical in determining whether this spending is justified. To date, increases in literacy, help-seeking intentions or campaign reach are often used as markers of success, while behavioural outcome data is limited. Perhaps these outcomes are enough to argue campaigns of this kind are useful but an inadequate prevention strategy.

It is insufficient to suggest changing awareness is akin to reducing suicide rates, but the nature of these initiatives, historically, has led to a deficiency in—or absence of—evaluation (especially of behavioural outcomes). Long-term follow-up is also required to ascertain the enduring benefits of such

campaigns. As new campaigns emerge, rigorous, mixed-method, longitudinal evaluation must be embedded in planning. While there is little evidence of specific harms (i.e. contagion) associated with suicide awareness campaigns, evaluation is also fundamental in this regard.

Campaigns appear to be most effective when they deliver considered, measured and sustained messages and embed behavioural change techniques or specific service provision.

Furthermore, program tailoring to specific risk populations and careful consideration of messaging is critical and can be achieved through community

engagement and a process of experience-based co-design. Evidence also indicates that campaigns delivered as part of multi-component suicide prevention strategies show the most promise. However, with an increased understanding of the need for integrated approaches, determining the effectiveness of specific elements is difficult. Therefore, awareness campaigns in the context of these multi-component strategies should have clear justification and attempts should be made where possible to isolate the effects of such campaigns and the active mechanisms of the messages themselves.

Campaigns appear to be most effective when they deliver considered, measured, and sustained messages and embed behavioural change techniques or specific service provision.

Recommendations

- 1

Co-ordinate community engagement to tailor appropriate campaigns to high-risk groups.
- 2

Include lived experience and diverse populations in campaign design from their outset and throughout.
- 3

Ensure all campaigns include an evaluation to determine their effect across a range of measures (help-seeking attitudes and help-seeking behaviours, lowered suicide attempts and suicide). These should include longer-term outcomes and the use of strong research design along with impacts on subgroups.
- 4

Investment in research to understand the effect of campaigns as a whole and individual components and mechanisms of action.
- 5

Invest in and promote campaigns that go beyond awareness raising and include components that are likely to have a positive impact on behaviour change.
- 6

Embed effective campaigns within multicomponent suicide prevention strategies that incorporate service-level augmentation at the state and community level.

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4

Needs driven, community integrated and data informed: next steps for suicide prevention

K. Huckvale, K. Mok, M. Larsen

Innovation in suicide prevention requires a clear strategy with a focus on aspirational, achievable and evidence-based objectives. How can we better plan, co-ordinate and implement in order to achieve breakthroughs in suicide prevention? What do those who work in the field consider to be our best opportunities to accelerate progress over the next 10 years?

Introduction

This chapter summarises recent survey findings regarding innovations in suicide prevention. In August 2020, we invited people involved across the spectrum of suicide prevention to identify the ‘best bets’ to prevent suicide over the next 10 years and the factors that might help or hinder their attainment.

The survey was not intended to yield an exhaustive list of all available innovations, but rather to identify those perceived as most promising by people actively involved in suicide prevention (see Table 1). The resulting innovations include new treatments, technologies, care models and services.

We received responses from 37 individuals representing 31 organisations. Respondents included leaders in suicide prevention: service providers, academics, community and lived experience advocates, and public servants. While most were based in Australia, the remainder

spanned 11 countries, including the United States, the United Kingdom, Canada and China.

After grouping best-bet-related ideas, we searched for relevant, publicly available information, including website and technical reports and peer-reviewed research evidence. We used this to further group and prioritise suggestions based on their stage of development, the existence of supportive outcomes evidence, and their relevance to an Australian context (see Table 1). Respondents’ suggestions for actions that could promote the development and adoption of innovations by policymakers

and commissioners were reviewed and combined. We then developed the headline recommendations presented at the end of this chapter and which are based in the sections below.

Section 1 presents innovations for which there is strong evidence of potential. Encouragingly, several of these are part of current government-funded initiatives. Section 2 presents innovations for which there is some evidence of potential. Section 3 presents innovations for which there is limited evidence of their potential. Each section provides specific recommendations to suicide over the next ten years.

Uncertainty

Table 1: Identified innovations

Identified innovations	
Implementation ready	Continuity of care for people following discharge from hospital or inpatient care through psychosocial support and brief contact interventions Establishment of services reflecting local needs in non-medical settings, such as safe spaces, for people experiencing suicidal thoughts Service redesign, including diversity and lived experience, based on active involvement of people in their own treatment plans and care decisions; e.g. safety planning
The five-year horizon	Scale-up of multi-source data systems to inform suicide prevention and policy initiatives Establishment of real-time registers and dashboards of suicidality focused on frontline and service delivery information needs Whole system redesign incorporating community-based, quality-assured services that consider broader social and cultural factors and determinants of suicide behaviour and risk Adoption of peer-based suicide aftercare models for recovery that are supported by a professionalised peer workforce
Research priorities	Rapid-acting antidepressants for the medical management of acute suicidality Digital and online approaches to improving access to care and service delivery; e.g. screening and triage software systems and brief self-directed treatments using apps Improving upstream responses to people in distress and crisis; e.g. distress reduction and compassion training for first responders Adaptation of existing evidence-based therapies that focus on coping responses to trauma and situational and systemic stressors; e.g. problem-solving therapy
Long shots	Machine learning to predict suicide risk and provide tailored treatment Development of new psychotherapies and culturally informed and led models of treatment specifically targeting suicide

SECTION 1: Implementation-ready innovations

Innovations in this category were identified as priorities based on the evidence and respondent views. These innovations largely represent new or refined approaches to care that target suicide prevention and are driven by people with lived experience as service co-designers, support providers or consumers. They typically focus on the needs of a person at risk, with periodic follow-up to monitor progress and reinforce recovery goals.

Some of these innovations are cost-effective alternatives to traditional care ¹ . These services operate within community settings to create a less medical and more familiar environment. They might involve employing peer workers who are responsible	for supporting service users. Some might also be connected to clinical services that service users can access as required (see Case Study 1). Examples include psychosocial aftercare ² , brief contact interventions ³ , safe spaces and respite centres	that offer short-term support. Although some alternatives are being trialled in Australia (e.g. The Way Back Support Service ⁴) or implemented in specific settings (e.g. Safe Haven Café Melbourne ¹), they do not represent routine care.
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CASE STUDY 1: Pieta House

Pieta House is a community-based service in Ireland that offers free counselling and therapy to people experiencing suicidal thoughts or engaging in self-harm, or to people bereaved by suicide. The service is based on a clearly defined, evidence-based intervention model called the Pieta House Suicide Intervention Model (PH-SIM)⁵. As of 2020, Pieta House operates 15 centres and five outreach services across the country. A trained therapist works collaboratively with individuals to identify physical, emotional and aspirational needs and to develop the practical skills and protective factors that address these needs. In the six weeks following

therapy, people receive a follow-up text message, letter and phone call to remind them of available support and services and to check in on their progress. <https://www.pieta.ie>

Key outcomes

Statistically significant changes in self-rated measurements after therapy, including:

- increased desire to live
- decreased levels of depression and suicidal ideation
- increased levels of self-esteem post therapy.

In addition, survey respondents also revealed a focus on innovation in the provision of existing care that encourages the active involvement of service users in their own treatment plans and care decisions. The idea that therapy should seek	to build a shared understanding between therapist and client of the subjective experiences contributing to suicide risk is not new ⁶ . However, evidence-based interventions and frameworks built around this principle are only now becoming established.	These can be complete programs that emphasise collaboration between person and clinician (see Case Study 2) or discrete components of care, such as the use of safety/crisis response plans.
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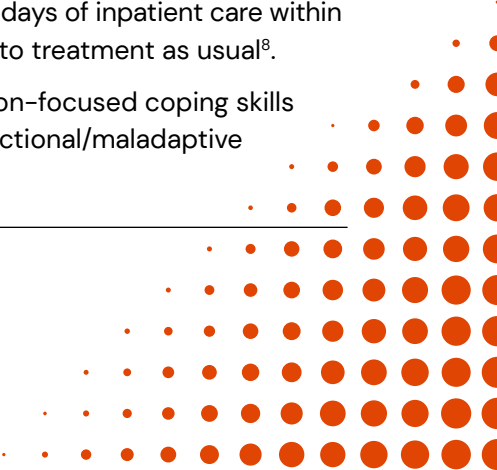
CASE STUDY 2: Attempted Suicide Short Intervention Program (ASSIP)

ASSIP is a brief therapy for people who have recently attempted suicide. The model emphasises a person-centred approach and a collaborative relationship between the person and clinician to create a strong therapeutic alliance⁷. It is administered in three 60–90-minute sessions that explore the person’s mental state leading up to their suicide attempt. The goal is to develop a practical plan to ensure safety in the future based on the person’s long-term goals, their warning signs and coping strategies. Participants then receive periodic

follow-up letters over the next 24 months to remind them of their strategies <https://assip.ch/>

Key outcomes

- Greater reduction in repeat suicide attempt risk within two years compared to treatment as usual⁸.
- Greater reduction in days of inpatient care within one year compared to treatment as usual⁸.
- Strengthened solution-focused coping skills and reduced dysfunctional/maladaptive coping strategies⁹.



Recommendation 1

Accelerate the scale-up of evidence-based, non-clinical programmes, such as psychosocial aftercare, brief contact interventions and safe spaces, that address key gaps in the availability of services and support options for different levels of suicidality. This should include consideration of cultural healing modalities in conjunction with westernised models.

In addition to targeted funding for these programs, action is needed to facilitate their use by formalising referral pathways and guidelines and by promoting provider and community awareness of newer services. Further, there are a range of potential practical and legal barriers to be addressed, such as current risk management protocols that fail to direct individuals in crisis into non-clinical services at the point of triage. Beyond the immediate term, governments should consider establishing an Australian standard for

comprehensive support and recovery for those at risk of suicide—because ‘one size cannot fit all’, a variety of quality assured, evidence-based clinical and non-clinical treatment options are needed for each level of suicidality. Cultural governance and treatment models that support holistic and spiritual wellbeing also require consideration. Without co-ordinated action, there is a risk that the increasing variety of treatment options results in a fragmented approach to suicide prevention, with unacceptable variation in services and outcomes.

Recommendation 2

Embed the active involvement of people in their own treatment plans and care decisions as a guiding principle for all suicide prevention services.

Recognising that subjective experience, socio-cultural context and needs critically shape the kinds of support that are most appropriate and helpful, each service user should be actively involved in their own treatment plans and care decisions. This is likely to require:

- training for staff across different services, within and beyond health and mental health sectors, in therapeutic frameworks or interventions that emphasise collaborative care and that empower individuals to make informed choices to select from a range of support options
- infrastructure and incentives that enable and encourage staff to enact person-centred and trauma-informed care¹⁰ (e.g. continuing professional development points, clinical tools)
- continuous quality assurance and continuous innovation to improve care¹¹, particularly for people who identify as Aboriginal and Torres Strait Islander and/or LGBTQI+
- research that reflects recommended cultural practices and research designs to understand and improve care in varied settings for different people
- building the capacity of people with lived experience to participate in research, service co-design and service delivery. This may include operationalising and refining existing frameworks (e.g. NSW Mental Health Commission Lived Experience Framework¹², LifeSpan Lived Experience Framework¹³) and leveraging existing mental health and emerging suicide prevention-specific workforces
- building the knowledge and acceptance of researchers, clinicians, policy and decision-makers to value, elevate and genuinely include lived experience expertise.

SECTION 2: The five-year horizon

While the innovations described above have been sufficiently developed and evaluated to recommend adoption in the short term, this section details innovations for which there is some evidence of their potential. As such, these are likely to be ready for adoption and wide-scale implementation within the next five years.

Respondents described innovations that involve the use of real-time data registers of suicide and self-harm, including the National Suicide and Self-Harm Monitoring system supported by a \$15M Federal Government investment in the Australian Institute of Health and Welfare and the National Mental Health Commission¹⁴. In the international context, a real-time system to track suicides or suspected suicides within the Thames Valley (UK) has allowed timely sharing of information with public health networks and a rapid response to contagion effects¹⁵. Geospatial mapping of incidents can also be used to isolate suicide clusters and hotspots to inform targeted local preventative measures¹⁶. Respondents also spoke of innovative integrated systems that link data from different sectors. These examples of multi-agency innovation can clarify participant contact and experiences with different services, as well as identify improvement opportunities. For example, Partners in Prevention examined police and ambulance responses in Queensland (see Case Study 3).

Respondents described innovations that involve the use of real-time data registers of suicide and self-harm ... innovative integrated systems that link data from different sectors ... community-based integrated services that are socially and culturally appropriate ... [and] peer-based and peer-led aftercare models.

CASE STUDY 3: Partners in Prevention

Partners in Prevention is a Queensland Health Suicide Prevention Taskforce-funded initiative that aims to improve first responses (i.e. police, ambulance) to suicidal distress or crisis¹⁷. Their work is informed by a review of the literature on models of care; a study examining knowledge, skills, attitudes, and confidence of police in responding to suicidal crisis; mapping of mental health and first responder services in Queensland; consultation with lived experience; and data linkage. More work is needed to evaluate the methodology for, and impact of, translating recommendations into practice. However, this initiative is a strong example of how data-informed

methods can drive the development of public health approaches to suicide prevention by identifying service gaps, the needs of service providers, and the needs of the consumer. <https://qcmhr.uq.edu.au/research-streams/forensic-mental-health/>

Key outcomes

Police and paramedics are the first responders for many suicide attempts; Partners in Prevention sought to improve this first contact experience. Previous research has shown that people with higher levels of satisfaction with these contacts are more likely to disclose future suicidality¹⁸; therefore, these positive experiences can support future help-seeking.

Respondents also recommended community-based integrated services that are socially and culturally appropriate. For example, the Eskasoni Mental Health and Social Work Service¹⁹ in Canada offers health, education, sports/recreation and mindfulness programs, along with mental health and addiction services for people with greater needs, to smooth

pathways into and out of the service. Given the appropriateness of this innovation for Indigenous Canadians, lessons might be garnered to inform how Indigenous Australians are supported. Respondents also described the emerging evidence for peer-based and peer-led aftercare models for recovery after a suicide attempt.

Peers already play a key role in several of the innovations described thus far, such as safe spaces. Various models are currently being trialled in Australia, including Lifeline’s Eclipse Support Groups, a peer-based adaptation of the Way Back Support Service, and integration of clinical and peer worker support in the Next Steps program (see Case Study 4).

CASE STUDY 4: Next Steps

Next Steps is a consumer-led program offering a combination of clinical and peer worker support for people who have presented to hospital at high risk of suicide but who do not require inpatient admission²⁰. After referral to the program, the individual (and carer/support person) meets with a clinician and peer worker, working collaboratively to set goals towards recovery. Their progress is reviewed at four weeks and at discharge (8–12 weeks). The peer worker, who has their own lived experience with mental health issues, closely supports the person to achieve these goals, with 3–4 visits per week during the first month and less frequent contact for a possible additional eight weeks. The peer worker might also facilitate referrals to other

health or community services to provide long-term support for the person, if needed. The Next Steps program was evaluated across a number of Grand Pacific Health services in NSW. <https://nswmentalhealthcommission.com.au/living-well-agenda/living-well-mid-term-review-2019/south-eastern-nsw/showcasing-next-steps-suicide>

Key outcomes

Next Steps provides the option of being released into the care of a GP as an alternative to being discharged from hospital, with active support during the most critical post-discharge period. The program demonstrated an integrated model of care that includes clinical services and peer workers.

Recommendation 3

Establish a clear roadmap, building on current state-level and federal initiatives, for the use of real-time, multi-sector and multi-source data in suicide prevention.

Barriers to sharing or integrating data between support services, agencies, jurisdictions and government remain. These limit the capacity of services to respond in a timely manner to changes in individual support needs and patterns of suicide risk. Consideration should be given to how data sharing can be supported and incentivised while ensuring appropriate privacy safeguards. Known limitations of existing datasets should also be considered when new services or models of care are being commissioned in order to maximise the value in ongoing monitoring of suicide and

policy responses. For example, key directions and frameworks for Aboriginal and Torres Strait Islander communities must be included. As the landscape of suicide prevention services evolves to include non-clinical and blended services operating outside established frameworks, the need for pragmatic and workable approaches to information sharing and monitoring will only grow. Consequently, a clear roadmap is needed for the use of real-time, multi-sector and multi-source data for suicide prevention, with explicit consideration of data needs, barriers and opportunities at local, regional, state and national levels.

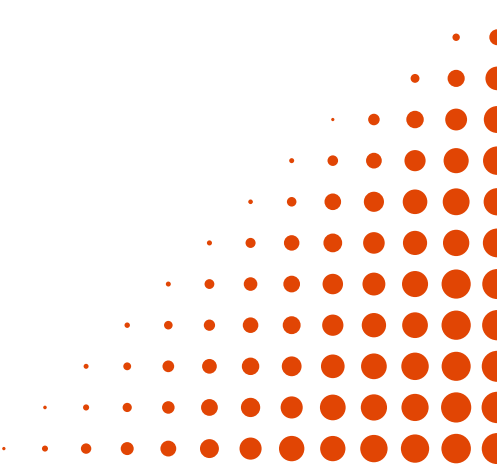
Recommendation 4

Support the professional development and integration of the suicide prevention peer workforce into suicide prevention services, recognising their emerging role in suicide prevention and aftercare services.

The professional development and integration of the suicide prevention peer workforce has an emerging role in suicide prevention and aftercare services. The Certificate IV in Mental Health Peer Work is a welcome step in the development of this peer workforce, as is the introduction of mandatory specialist training for peer workers in some settings; for example, as part of NSW’s Workforce Plan for Mental Health²¹. To protect peer workers and those experiencing thoughts of suicide, and to maximise the impact of investment in the peer workforce, there are several additional opportunities for action:

- Ensuring that the Peer Workforce Development Guidelines²² proposed under the Fifth National Mental Health and Suicide Prevention Plan address supervision/mentoring, ongoing professional development and career progression within this specialisation.

- Ensuring that governance, supervision and training expectations be represented in quality frameworks and workforce planning for blended and non-medical services that involve peer workers²¹.
- Proactively addressing capacity issues and cultural barriers to the introduction and integration of peer workers into existing workplaces (particularly clinical services).



SECTION 3: Research priorities

Innovations in this category are active research topics where their development or evaluation is insufficient to recommend their use, even though they focus on important unmet challenges in suicide prevention, such as rapidly and safely reducing suicidal thoughts in people experiencing crisis.

Active research topics [include] ... ketamine ... digital or online approaches to improving access to care ... improving existing system responses to people in distress or crisis ... [and] the introduction of evidence-based, theory-grounded therapeutic approaches that focus on psychosocial factors ...

This is most clearly illustrated by ketamine, an established anaesthetic drug which causes rapid, clinically relevant reductions in suicidal thoughts when used as a single dose or short course to treat people with pre-existing mental health conditions²³. People who have attempted suicide or self-harm and who require inpatient care are up to five times more likely to die by suicide in the 30 days after discharge than patients without a recent history of self-harm²⁴. As a result, ketamine may have a future role as a ‘rescue’ medication administered in acute care to alleviate immediate distress and reduce the risk of re-attempt. However, ketamine has limitations: for instance, its effects are short lived^{23,25}; it cannot address personal and situational contributors to self-harm or suicide; there is limited clarity on how to ensure informed patient consent; and how it compares with alternative treatments, like brief psychological therapy, remains unknown. As such, ketamine might form one part of a comprehensive regimen that also involves the assessment and management of mental health, before, during, and post an inpatient admission.

Other promising innovations include:

- digital or online approaches to improving access to care and service delivery. The concept of using smartphones and apps to support self-directed treatment and improved communication with care providers is not new in mental health^{26,27} but is at an early stage of development in suicide prevention. There is nevertheless promising evidence that interventions that directly target suicidal ideation (rather than more general mental health) are effective, at least in the short term²⁸. There remain, however, challenges of equity of access to technology-supported programmes/interventions, digital literacy, acceptability and digital service non-use/attrition. Positive steps to address these barriers include greater recognition of the value of user-centred, culturally sensitive design²⁹ and lived experience involvement³⁹ within the intervention and service development and evaluation processes.
- One way to accelerate progress is to prioritise for implementation ‘digital best bets’—that is, digital versions of established, evidence-based therapies for suicide prevention, such as cognitive/dialectical behavioural therapy²⁸, evaluative conditioning²⁸ or brief contact interventions³ (Case Study 5).

At a care co-ordination level, respondents also identified the potential of digital tools to co-ordinate screening, triage and prevention in both medical and non-medical contexts, such as schools. The cost-effectiveness and feasibility of the implementation of these systems in different settings requires further exploration.

- improving existing system responses to people in distress or crisis; for example, by providing distress reduction training with a focus on compassion and understanding for frontline workers or by offering rapid access to brief problem-solving and distress management interventions³⁰. The results of evaluations currently underway are needed before recommendations can be made.
- the introduction of evidence-based, theory-grounded therapeutic approaches that focus on psychosocial factors contributing to suicide risk, such as problem-solving skills³¹ or interpersonal relationships. Because these approaches are already used in the management of mental health conditions such as depression, they are likely to be feasible; however, specific evidence of outcomes benefit in suicide is still needed.

CASE STUDY 5: Digital brief contact interventions—RAFT

Reconnecting AFTer a suicide attempt (RAFT) builds upon the existing evidence base for brief contact interventions³ with a digitally delivered text message program. There is emerging evidence that this delivery mode can help people reconnect with health services and sources of support if suicidal distress re-emerges³³. RAFT extends these messages with links to online support content.

The program was designed in partnership with people with lived experience of suicide³⁴ and has been piloted at two hospitals. Preliminary findings show strong engagement, with positive responses related to feeling more connected. A large-scale evaluation of RAFT is currently underway, supported by Suicide Prevention Australia.

A few respondents noted that artificial intelligence (machine learning) can be used to predict individual suicide risk based on online and social media activity^{35,36},

self-reports and sensor-based behaviour tracking³⁷, resulting in opportunities to provide tailored treatment advice within digital treatments, such as apps. Despite limited evidence on

their capacity to reduce suicide, these innovations might help to develop tailored responses to accommodate individual needs and preferences en masse.

Recommendation 5

Work with Suicide Prevention Australia, the NHMRC, the MRFF and the National Mental Health Commission to establish a strategic, long-term/recurring ‘innovation-to-implementation’ funding stream for the most promising approaches to suicide prevention.

Respondents highlighted funding for large-scale trials as a specific challenge for suicide prevention research. There are several factors that, together, make suicide prevention unlike other clinical research areas. These include:

a. the unique challenges of outcomes assessment in suicide prevention

b. implementation within already complex systems of care

c. the potential requirement for local, culturally sensitive adaptations to programs and services to reflect the specific needs of those with lived experience and their communities.

Together, these factors mean that longer time frames, sustained investment and real-world evaluation are needed to demonstrate meaningful impacts and cost-effectiveness in suicide prevention research. That Australia is a leader in several of the identified research priorities underlines the potential for strategic investment.

Recommendations

- 1 Accelerate the scale-up of evidence-based, non-clinical programmes, such as psychosocial aftercare, brief contact interventions and safe spaces, that address key gaps in the availability of services and support options for different levels of suicidality.
- 2 Embed the active involvement of people in their own treatment plans and care decisions as a guiding principle for all suicide prevention services.
- 3 Establish a clear roadmap, building on current state-level and federal initiatives, for the use of real-time, multi-sector and multi-source data in suicide prevention.
- 4 Support the professional development and integration of the suicide prevention peer workforce into suicide prevention services, recognising their emerging role in suicide prevention and aftercare services.
- 5 Work with Suicide Prevention Australia, the NHMRC, the MRFF and the National Mental Health Commission to establish a strategic, long-term/recurring ‘innovation-to-implementation’ funding stream for the most promising approaches to suicide prevention.


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