Suicide Prevention

Edited by Justin Healey

ISSUES IN SOCIETY
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INTRODUCTION

Suicide Prevention is Volume 377 in the ‘Issues in Society’ series of educational resource books. The aim of this series is to offer current, diverse information about important issues in our world, from an Australian perspective.

KEY ISSUES IN THIS TOPIC

Suicide is a tragedy which touches many people. Each year around one million people commit suicide worldwide. These deaths can have lasting and devastating impacts on families and friends affected by suicide, as feelings of grief and loss are clouded by complex questions of life and death which remain unanswered.

Deaths caused by suicide are however, preventable. Encouragingly, Australia’s suicide rate has decreased by 17% over the past decade (ABS, 2012), however suicide remains the leading cause of death among Australians 15-34 years of age. What are the risks and warning signs for people contemplating this devastating, final act?

This book informs young people, parents and educators about suicide awareness, intervention and prevention. Life is worth living, help and support are at hand.

SOURCES OF INFORMATION

Titles in the ‘Issues in Society’ series are individual resource books which provide an overview on a specific subject comprised of facts and opinions.

The information in this resource book is not from any single author, publication or organisation. The unique value of the ‘Issues in Society’ series lies in its diversity of content and perspectives.

The content comes from a wide variety of sources and includes:

- Newspaper reports and opinion pieces
- Website fact sheets
- Magazine and journal articles
- Statistics and surveys
- Government reports
- Literature from special interest groups

CRITICAL EVALUATION

As the information reproduced in this book is from a number of different sources, readers should always be aware of the origin of the text and whether or not the source is likely to be expressing a particular bias or agenda.

It is hoped that, as you read about the many aspects of the issues explored in this book, you will critically evaluate the information presented. In some cases, it is important that you decide whether you are being presented with facts or opinions. Does the writer give a biased or an unbiased report? If an opinion is being expressed, do you agree with the writer?

EXPLORING ISSUES

The ‘Exploring issues’ section at the back of this book features a range of ready-to-use worksheets relating to the articles and issues raised in this book. The activities and exercises in these worksheets are suitable for use by students at middle secondary school level and beyond.

FURTHER RESEARCH

This title offers a useful starting point for those who need convenient access to information about the issues involved. However, it is only a starting point. The ‘Web links’ section at the back of this book contains a list of useful websites which you can access for more reading on the topic.
CAUSES OF DEATH: SUICIDE IN AUSTRALIA

This extract from the latest Causes of Death, Australia report by the Australian Bureau of Statistics presents a statistical summary of suicide deaths registered in Australia.

OVERVIEW

In 2010, a senate inquiry (The Hidden Toll: Suicide in Australia) highlighted the potential costs of suicide to individuals, families and communities. Suicide can be defined as the deliberate taking of one’s life (Butterworths Concise Australian Legal Dictionary, 1997, Butterworths Sydney). To be classified as a suicide, a death must be recognised as being due to other than natural causes.

This chapter contains summary statistics on suicide deaths registered in Australia, where the underlying cause of death was determined as Intentional self-harm (suicide (X60-X84, Y87.0)). Further information on suicides is presented in the data cubes associated with this publication.

External causes of death are required to be examined by the coroner, who investigates both the mechanism by which a person died, and the intention of the injury (whether accidental, intentional self-harm or assault). For a death to be determined a suicide, it may be established by coronial inquiry that the death resulted from a deliberate act of the deceased with the intention of ending his or her own life (intentional self-harm). In addition to coroner-determined suicides, deaths may also be coded to suicide following further investigation of information on the National Coronial Information System.

SUICIDES, NUMBER OF DEATHS, 2003-2012

[Graph showing the number of male, female, and total suicide deaths from 2003 to 2012]
There were 2,535 deaths from Intentional self-harm (suicide, (X60-X84, Y87.0)) in 2012, resulting in a ranking as the 14th leading cause of all deaths. Three-quarters (75.0%) of people who died by suicide were male, making suicide the 10th leading cause of death for males. Deaths due to suicide occurred at a rate of 11.0 per 100,000 population in 2012.

Suicide as proportion of total deaths

While suicide accounts for a relatively small proportion (1.7%) of all deaths in Australia, it accounts for a greater proportion of deaths from all causes within specific age groups (see graph above). For example, in 2012, over a quarter of deaths of males in the 20-24, 25-29 and 30-34 year age groups were due to suicide (28.7%, 26.5% and 27.5%, respectively). Similarly for females, suicide deaths comprise a higher proportion of total deaths in younger age groups compared with older age groups (32.6% of deaths of 15-19 year olds and 25.2% of deaths of 20-24 year olds).

**AGE**

**Median age**

The median age at death for suicide in 2012 was 44.6 years for males, 42.8 years for females and 44.1 years overall. In comparison, the median age for deaths from all causes in 2012 was 78.6 years for males, 84.6 years for females and 81.7 years overall.

**Age-specific rates**

Age-specific death rates are the number of deaths during the reference year for specific age groups per 100,000 of the estimated resident population of the same age group. The pattern of age-specific rates in 2012 for suicide in males and females is shown in the graph on the following page.

The highest age-specific suicide death rate for males in 2012 was observed in the 85 years and over age group (37.6 per 100,000 males). As a proportion of total male deaths in this age group, suicide deaths represented 0.3%. The second highest age-specific suicide rate was observed in the 80-84 year age group, with 28.1 suicide deaths per 100,000 males. Suicide as a proportion of total male deaths for this age group was 0.4%. Excluding the 0-14 year age group, the age-specific suicide rate for males was lowest in the 15-19 year age group (9.3 deaths per 100,000), however, this represented over a fifth of all deaths in this age group (21.0%).

For females the highest age-specific suicide death rate
in 2012 was observed in the 80-84 year age group, with 9.5 deaths per 100,000. Outside of the 0-14 year age group, the lowest age-specific death rate for female deaths was in the 65-69 year age group (4.1 deaths per 100,000).

**Age-standardised rates**

Age standardisation is used to compare death rates over time, as it accounts for any changes in the age-structure of a population over time. The age-standardised suicide rate for persons in 2012 was 11.0 per 100,000. This compares with 11.2 per 100,000 in 2003.

The age-standardised suicide rate in 2012 for males was 16.8 per 100,000 while the corresponding rate for females was 5.5 per 100,000.

**Suicide by year of occurrence**

Sections 1-7 (including this section on suicide deaths) of the *Causes of Death, Australia* publication are based on year of registration data (e.g. when the death was registered). Section 8 is based on year of occurrence (e.g. the year the death actually occurred).

For the 2012 reference year, 10.3 of deaths had a year of occurrence prior to 2012. This compares with the 2011 reference year where 7.0% of deaths occurred prior to 2010, and the 2010 reference year where 9.1% of deaths occurred prior to 2010.

The number of deaths that are registered in any year will be different to the number of deaths that actually occurred in that year. Counts of specific causes of death (including suicide) based on year of occurrence are available for 2002-2011 in the Year of Occurrence datacube.

The proportion of suicide deaths that occur in a previous reference period can impact the overall count of suicide deaths, along with coronial investigations not being finalised and the revisions process undertaken by the ABS.

**Suicide deaths of children and young people under the age of 15**

The number of suicide deaths of children and young people under the age of 15 is small, but is significant in terms of the proportion of all deaths within this age group. The tables provided below show aggregate data for the 5 year period from 2008-2012. The age group published is for persons 5 to 14 years of age. This aligns with standards used elsewhere in the Cause of Death release and with those used by the World Health Organisation (WHO). The ABS is not aware of any recorded suicide deaths of children under the age of 5.

Deaths of children by suicide is an extremely sensitive issue. The number of deaths of children attributed to suicide can be influenced by coronial reporting practices. Reporting practices may lead to differences in counts across jurisdictions and this should be taken into account when interpreting these data.

The following two tables present the number of deaths from suicide by age group for the 2008-2012 reference period. *Table 5.1* shows the number of deaths from suicide and age-specific death rates by age group and sex. *Table 5.2* shows the number of deaths from suicide by age group and state or territory of usual residence.

It is recognised that the death rate from suicide differs between Aboriginal and Torres Strait Islanders and non-Indigenous Australians. While not separately tabulated, it should be noted that of the 57 deaths by suicide of children and young people under the age of 15, 15 deaths (26.3%) were of Aboriginal and Torres Strait Islander Australians. The remaining deaths were of non-Indigenous persons or persons for whom Indigenous status was not stated.
In 2012, the most frequent method of suicide was hanging, strangulation and suffocation (X70), a method used in more than half (54.4%) of all suicide deaths. Poisoning by drugs (X60-X64) was used in 14.5% of suicide deaths, followed by poisoning by other methods (X65-X69) including by alcohol and motor vehicle exhaust (8.5%). Methods using firearms (X72-X74) accounted for 6.8% of suicide deaths. The remaining suicide deaths included deaths from drowning, jumping from a high place, and other methods.

**Mechanism by intent – selected causes**

Coronial processes to determine the intent of a death (whether intentional self-harm, accidental, homicide, undetermined intent) are especially important for statistics on suicide deaths because information on intent is necessary to complete the coding under ICD-10 coding rules. Coroners’ practices to determine the intent of a death may vary across the states and territories. In general, coroners may be reluctant to determine suicidal intent (particularly in children and young people). In some cases, no statement of intent will be made by a coroner. The reasons may include legislative or regulatory barriers, sympathy with the feelings of the family, or sensitivity to the cultural practices and religious beliefs of the family. For some mechanisms

**TABLE 5.1: SUICIDE, NUMBER AND AGE-SPECIFIC RATES OF DEATH BY AGE GROUP AND SEX, 2008-2012**

<table>
<thead>
<tr>
<th>Cause of Death and ICD-10 code</th>
<th>Males</th>
<th>Females</th>
<th>Persons</th>
<th>Males rate(c)(d)</th>
<th>Females rate(c)(d)</th>
<th>Persons rate(c)(d)</th>
</tr>
</thead>
<tbody>
<tr>
<td>5-14</td>
<td>29</td>
<td>28</td>
<td>57</td>
<td>0.4</td>
<td>0.4</td>
<td>0.4</td>
</tr>
<tr>
<td>15-24</td>
<td>1,119</td>
<td>410</td>
<td>1,529</td>
<td>14.2</td>
<td>5.5</td>
<td>10.0</td>
</tr>
<tr>
<td>25-34</td>
<td>1,698</td>
<td>469</td>
<td>2,167</td>
<td>21.5</td>
<td>6.1</td>
<td>13.9</td>
</tr>
<tr>
<td>35-44</td>
<td>2,021</td>
<td>591</td>
<td>2,612</td>
<td>26.0</td>
<td>7.5</td>
<td>16.6</td>
</tr>
<tr>
<td>45-54</td>
<td>1,823</td>
<td>572</td>
<td>2,395</td>
<td>24.4</td>
<td>7.5</td>
<td>15.9</td>
</tr>
<tr>
<td>55-64</td>
<td>1,182</td>
<td>374</td>
<td>1,556</td>
<td>19.0</td>
<td>6.0</td>
<td>12.4</td>
</tr>
<tr>
<td>65-74</td>
<td>653</td>
<td>183</td>
<td>836</td>
<td>16.4</td>
<td>4.5</td>
<td>10.4</td>
</tr>
<tr>
<td>75-84</td>
<td>499</td>
<td>142</td>
<td>641</td>
<td>22.7</td>
<td>5.2</td>
<td>13.0</td>
</tr>
<tr>
<td>85 and over</td>
<td>212</td>
<td>67</td>
<td>279</td>
<td>32.2</td>
<td>5.3</td>
<td>14.4</td>
</tr>
<tr>
<td>All ages(e)</td>
<td>9,236</td>
<td>2,837</td>
<td>12,073</td>
<td>16.8</td>
<td>5.1</td>
<td>11.0</td>
</tr>
</tbody>
</table>

a. All causes of death data from 2006 are subject to a revisions process – once data for a reference year are ‘final’, they are no longer revised. Affected data in this table are: 2008-2010 (final), 2011 (revised), 2012 (preliminary). See Explanatory Notes 29-33 and Technical Notes, Causes of Death Revisions, 2006 in the Causes of Death, Australia, 2010 publication, and Causes of Death Revisions, 2010 and 2011 in this publication.

b. Includes ICD-10 codes X60-X84 and Y87.0. Care needs to be taken in interpreting figures relating to suicide. See Explanatory Notes 92-94.

c. Age-specific rates of deaths are the number of deaths per 100,000 population.

d. The age-specific rates published in this table are calculated for the 2008-2012 reference period. As such, they may differ from age-specific rates published elsewhere in the Causes of Death which are calculated for a single year.

e. Includes deaths of persons whose age was not stated.
of death where it may be very difficult to determine suicidal intent (e.g. single vehicle accidents, drownings), the burden of proof required for the coroner to establish that the death was suicide may make a finding of suicide less likely.

The table below presents selected external causes of death by mechanism and intent. It is possible that additional suicide deaths are contained within the Intent categories of Accidental and Undetermined Intent, particularly for the mechanisms of poisoning and hanging.

The facts about safe reporting of suicide

Journalists should be cautious when reporting about suicide, explains Kairi Kolves from the Australian Institute for Suicide Research and Prevention

The issue of media reporting of suicide was once again thrust into the spotlight this week, with mental health researcher, clinician and former Australian of the year Pat McGorry renewing his calls for a new approach to reporting suicide.

Writing in the Fairfax papers, McGorry said: "Just as we’ve done with the road toll, the mainstream media should report frequently and prominently a tally of lives lost to suicide through a national campaign funded by the federal government."

Suicide is a multidimensional problem that encompasses biological, psychological and social factors. But while it’s important to encourage greater community discussion about seeking help for mental distress, we need to tread very carefully when it comes to reporting suicide.

Suicide contagion

Suicide research suggests that certain types of media reporting may trigger further suicidal behaviours among vulnerable people.

This form of contagion has often been referred to as the Werther effect, which comes from Goethe’s 1774 novel The Sorrows of Young Werther, in which a young fellow shoots himself because he can’t cope with the pain of unrequited love. The story was said to have prompted a wave of real-life copycat suicides throughout Europe.

But evidence-based research on the media reporting of suicide really only started only in the 1960s.

Recent large-scale reviews of the evidence by Australian researchers Jane Pirkis and Warwick Blood found there was an association between the non-fictional (news) media portrayal of suicides and actual suicidal behaviours. The results weren’t so clear about the fictional portrayal of suicides.

The negative effect of news media reporting has been attributed to:

- Presentation of suicide method
- Front page coverage and use of images and large headlines.

Media reporting has been shown to emphasise single factors (such as the global financial crisis), over-report rare and lethal suicide methods (jumping), and under-report the influence of mental health problems.

Young people and the elderly are more likely to be affected by the media portrayal of suicidal behaviours than the middle-aged.

Reducing the risk

In order to avoid suicide contagion and to promote responsible media reporting of suicidal behaviours, several countries have developed or adopted media guidelines in accordance with World Health Organization and International Association for Suicide Prevention recommendations in the past decade.

It’s important to note that media guidelines don’t dictate to journalists what to do. Rather, they aim to empower and encourage journalists to collaborate with researchers and public health policy makers to help save lives by reporting in a responsible manner.

There is still limited evidence on the preventative effects of the media’s reporting of suicide. But one example of media reporting successfully reducing suicidal behaviours was in the wake of Kurt Cobain’s death in 1994. There was no contagion effect and calls to crisis hotlines increased. This has been attributed to the professional and responsible media portrayal of his death and subsequent crisis intervention (the presentation of crisis hotline numbers).

Another example is the introduction of media guidelines in Austria, which were found to increase the quality of reporting...
and reduced suicidal behaviours. Importantly, the reporting on people with suicidal ideation who had made use of positive coping mechanisms was linked with a reduction in suicides.

The researchers coined this phenomenon the Papageno effect, which refers to the Mozart opera *The Magic Flute*, in which a young man in love has suicidal ideation, but receives help and learns to cope well.

**Reporting suicide in Australia**

Some researchers have investigated the effect of media guidelines on the quantity and quality of reporting suicides.

The Australian guidelines for reporting suicide, prepared by Mindframe National Media Initiative, were released in 2002. An impact analysis showed the guidelines led to an almost two-fold increase in the number of news reports about suicide and, importantly, improved the quality of reporting.

After recent public discussions about the portrayal of suicides in the media, the Australian Press Council updated the guidelines for reporting suicides last year.

A number of challenges remain for journalists. The pain caused to family and people left behind by suicide is tremendous, and their voices should be heard. But this doesn’t necessarily mean details of suicides should be published. After all, we still don’t have any evidence about the effect of the portrayal of bereaved by suicide in the media.

We certainly shouldn’t avoid talking about suicide. Indeed, the evidence supports discussions about suicide in the context of help-seeking possibilities and interventions. But journalists should be cautious when presenting the topic and follow the guidelines for responsible media reporting.

For help or information call Lifeline on 13 11 14, Kids Helpline on 1800 55 1800 or MensLine Australia on 1300 78 99 78 or visit beyondblue.org.au

Kairi Kolves is Senior research fellow at the Australian Institute for Suicide Research and Prevention, National Centre of Excellence in Suicide Prevention at Griffith University.

**SUICIDE ATTEMPTS**

- It has been estimated that over 2.1 million Australians have seriously considered suicide in their lifetime and over half a million people have acted on these thoughts.
- Each year, about 65,300 people attempt to take their own life. The patterns of inequality we have seen in suicide rates are also reflected in attempts, with the exception that women are more likely to attempt suicide than men.
- The biggest risk factor for a completed suicide is a previous attempt. We know from international evidence that for people who sought hospital Emergency Department (ED) treatment following a suicide attempt, one in six attempts is followed by another within the following 12 months, and that up to one in twenty of those people attempting suicide will die by suicide during the next nine years.

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SUICIDE – THE DISCLOSURE DILEMMA

Until we are able to openly disclose and discuss suicide, we will fail in our goal of making a significant impact on our suicide rates, comments Steve Ellen

In my time as a public hospital psychiatrist, I’ve seen many suicides. It is the most common cause of death for those aged under 45. Despite this statistic and suicide's undeniable presence in our society, it remains for the most part, the elephant in the room.

The founding chairman of beyondblue, Jeff Kennett, recently wrote yet another excellent article drawing this tragedy into the national consciousness. In it, he called for two things: greater funding of suicide prevention campaigns and a greater community conversation about suicide. But without the second, the first is wasted money.

Last month, the Australian Bureau of Statistics once again reminded us that despite decades of efforts in the mental health arena we have not made a difference to suicide rates. Our rate remains stubborn at 11 per 100,000 people per year, which translates to around 2,500 people per year or about twice the national road toll.

In contrast to the open and accepted discourse around road tolls in our community, suicide is often kept hidden. I’ve seen numerous suicides disguised as other medical problems – sudden heart attack and brain haemorrhages, among other things. The fact is that families are frequently loathe to disclose suicide. The stigma associated with suicide inevitably casts a veil of secrecy that continues to foster this culture of silence.

The consequence of this secrecy is that it limits our ability to measure the extent of the problem, to research suicide and, most importantly, to provide help to those at risk. Until we are able to openly disclose and discuss suicide, we will fail in our goal of making a significant impact on our suicide rates.

WHY THE SECRECY?

I respect any family’s right to privacy. And losing a loved one to suicide is a tragedy almost beyond comprehension. Family and friends often feel like they have failed somehow. Why didn’t they recognise the problem? Why didn’t they do more to prevent it? Blame often flows freely. Guilt and grief are powerful, sometimes overwhelming emotions.

Some religious practices encourage secrecy. It is a sin in some religions, forbidden in others, and often the funeral and burial practices must change if death was by suicide. There are also legal implications. In some countries suicide remains a criminal act, and in some circumstances families can be penalised. In Australia suicide and attempting suicide is no longer a criminal act, although assisting or encouraging suicide is an offence. There may also be implications for insurance and other legal matters.

Another contributory factor is the fear in the media around discussing suicide because of the risk of copycat suicides. There is some evidence to support this view. But media reporting guidelines have softened in the past decade from a point where suicide was barely mentioned to the current state where it is reported but within guidelines that aim to minimise any sensationalism and provide contact details for support services.

Finally, there is the language around suicide – it evokes images of crime and guilt. The word “commit” – “she committed suicide” – has negative connotations. Commit implies a crime. We commit murder, we commit rape – we don’t commit marriage, we don’t commit childbirth. Suicide should not be included in acts we commit. As the Australian Psychological Society notes, we need different language around suicide.

She attempted to end her life. He died by suicide.

UNCOVERING THE SECRECY

Let’s be clear – the reasons for the secrecy are entrenched and complex. I’m not criticising families for making up stories – how could I, in the midst of such grief and sorrow? I don’t know how I would cope. The decision to disclose must remain theirs, and theirs alone.

But ignorance will never shift the elephant in the room. We and the families need to be aware that every time we hide suicide we contribute to the secrecy, the stigma, and the knowledge gap around this national tragedy. If we as individuals and a community talk freely, without prejudice or sensationalism, then we will slowly lift the veil. We might finally make some progress and like the toll from road accidents, the rates might finally fall.

For support in a crisis, contact Lifeline on 13 11 14. For information about depression and suicide prevention, visit beyondblue or SANE Australia.

Acknowledgement

Miriam Ercole contributed to the preparation of this column.

Steve Ellen is Adjunct Associate Professor of Psychiatry at Monash University.
Suicide: a fact sheet for young people

This fact sheet from the Women’s and Children’s Health Network provides information aimed at helping young adults to understand suicide.

Every year around the world, young people lose their lives to suicide. In Australia nearly as many young people die from suicide as die in car accidents.

The suicide rates for some groups of young people are higher than others. Young people living in the country, Aboriginal young people, young people living with a mental illness, and gay and lesbian young people have higher rates of youth suicide than other young people.

Suicide of young people is a matter of great concern. It is for this reason that it is important for young people to know the warning signs and what to do if you are worried.

**WARNING!**

If you feel like you are going to harm yourself, it is important to contact someone to talk about it now. Or contact your local hospital casualty department. If you are with a friend who is saying he or she is going to commit suicide now, stay with them. You could phone an emergency number, call for help from family or friends, or try and get your friend to the casualty department of your local hospital. It is important to also get some support for yourself as soon as possible.

In South Australia, phone Crisis Care on 13 16 11 in the evening or on weekends or, if you are over 18, the Assessment and Crisis Intervention Service (ACIS) on 13 14 65. You could also call Lifeline 13 11 14.

**WHY DO SOME PEOPLE COMPLETE OR ATTEMPT SUICIDE?**

We will never know the full personal reasons for each individual suicide.

What we do know is that young people usually don’t want to die, but what they do want is for the pain to stop. Often the person is feeling such deep pain and feels so bad inside that it seems that ending life is the only way to stop the pain. When you feel that bad it is hard to think about other choices or other ways to solve problems.

There are two main ideas about why people complete or attempt suicide. These are social stresses and depression.

**Stress**

Many people can feel highly stressed because of things like:

- Unemployment
- Having to do more and more at school because of being expected to have higher standards of education in today’s world to get a job – pressures at school
- A lot of family conflict
- Isolation and loneliness
- Having been abused as a child
- Trauma such as rape
- Losses such as loss of independence, e.g. someone who was active now being in a wheelchair because of an accident.

**Depression**

Sometimes people have an illness called depression. This is an illness where there are chemical changes in the brain and the ways of thinking, moods, behaviour and feelings become affected. This is more than the normal feelings of sadness that all people get from time to time. Different people describe depression differently and it may not feel exactly the same for any two people.

Depression can happen for several reasons:

- Sometimes it runs in families and is an illness
- Sometimes there are reasons like a family break up, child abuse, ongoing bullying at school, rape, a death or a relationship breaking up, family conflict, an ongoing illness or a permanent disability or several of these things happening close together
- Sometimes there is no obvious reason.
Depression can affect thinking so that it becomes too hard to try to get help or too hard to think of other ways out of a situation.

The things that are really hard to see when you're feeling down are:

• That the problems that seem unsolvable will change
• That life is always changing
• And that there are choices.

Out of the choices that a person has, suicide is the one permanent choice that can't be reversed. Today's situation will change. It can be really helpful to talk the situation through if you feel so bad that you think suicide is the only way to make a change.

**WHAT ARE THE WARNING SIGNS THAT SOMEONE MIGHT BE THINKING ABOUT SUICIDE?**

• Threats of suicide including talking about completing suicide, hinting at suicide or writing about suicide.
• Telling you plans about suicide.
• Having a way to suicide, like hoarding pills, having a gun or a rope.
• Previous attempts.
• Purposefully hurting themselves.
• Acting dangerously – getting into risky, scary, dangerous situations such as when they are driving.
• Signs of depression including not caring how they look, angry outbursts, fighting, missing school, being irritable, sudden changes in appetite, sleep patterns or behaviour.
• Making negative comments about themselves.
• Using a lot of alcohol or other drugs.
• Giving away possessions or making a will.
• Unexplained crying.
• No interest in the future.
• Loss of interest in things the person used to enjoy.
• Feeling out of control.
• Withdrawing from family and friends.
• Feelings of hopelessness and helplessness.
• Suddenly becoming cheerful after being really down for a long while.

There are links between some mental illness and suicide for example, depression, schizophrenia and psychosis.

**Not everyone who has the warning signs will go on to attempt suicide but they should always be taken seriously. There is no sure way to tell.**

If you know about the warning signs you may be able to help. It may take only something small to push someone who is thinking about it to taking the next step and attempting suicide, so it is important to take notice of warning signs.

**SUICIDE TRIGGERS**

If a young person has some of the warning signs, here are some things that could trigger an attempt at suicide:

• A relationship ending
• Being bullied at school
• The death or suicide of someone close, or the suicide of someone famous that the person really looked up to
• An argument at home
• Getting into trouble at home, at school, work or with the police
• Being abused
• Confusion over sexuality or being rejected due to sexuality
• Sometimes young people might attempt suicide when they are quite drunk or stoned because the drugs have helped them lose the fear of attempting suicide.

**WHAT IF I'M WORRIED ABOUT A FRIEND?**

**Take any threats of suicide seriously**

If you are with a friend who is saying he is going to complete suicide now, stay with your friend. Phone an emergency number. Ask the telephone operator if you don't know one. Or try and get your friend to the emergency department of your local hospital.

If you have a friend who is showing some of the warning signs and you're worried, here a few suggested dos and don'ts:

**Do**

• Talk to her – ask her how she is feeling and what is bothering her.
• Ask about suicide, speak openly – mentioning suicide will not give her the idea.
• Offer your unconditional friendship and support. That doesn't mean that you have to agree with everything she says or does but let your friend know you still care no matter what has happened to her or whatever she does.
• Listen to her. Listening isn't always easy – to really listen you need to listen with your ears, your eyes and your heart. It doesn't mean you have to find all the answers. What a person often needs more than anything is to feel understood. Try and listen and understand.
• Be non-judgemental.
• Look after yourself. You need to be healthy yourself if you are to offer support to a friend.
• Talk about the things that are good in her life, her strengths and the people who care and are supportive.
• For your friend’s safety it is important to tell a responsible adult that you trust.
• Your friend might need professional help. There is help around. Go to the Resources section at the end of this health topic.
Don’t

• Don’t tell your friend not to worry. Whatever is upsetting him may not be something that would upset you but it is very important to him. If you tell him it’s not really important it will seem that you don’t understand and you won’t be very helpful.
• Try not to seem shocked by anything your friend says. This could make it seem that you don’t understand.
• Don’t panic especially if your friend talks about feeling suicidal – it may be a relief to be able to speak openly and have someone understand how he feels.
• Don’t dare him to try it, make fun of it or use guilt to prevent suicide.
• Don’t leave your friend alone with anything that could be used to harm himself.
• Don’t try to handle this alone – for your friend’s safety it is important to tell a responsible person that you trust.

WHAT IF YOU ARE WORRIED ABOUT YOURSELF?

It’s important you don’t try to go it alone. Often when you feel this bad, you feel very much alone, isolated, as though no one cares and that there is no way out of whatever is happening right now. It can be like a valve inside your head that will only let the negative thoughts in and none of the positive thoughts.

Talk to someone that you feel comfortable with and who is responsible. Look at the list of resources at the end of this topic.

There is help around and it can be amazing how you can start to feel differently with someone else offering you support and exploring other choices with you. You could call Lifeline 13 11 14.

Sometimes you can be feeling really miserable because of a medical condition that you don’t even know you have and a doctor may be able to help. You may know a doctor or another health care professional that you can trust or you could have a look at Getting Health Care for hints about choosing someone you feel OK with. It’s important that you do contact someone.

MYTHS ABOUT SUICIDE

Myth
Asking someone if they are suicidal will put the idea into a person’s head.

Fact
Asking someone about suicide directly opens up the channels to be able to talk honestly. It will not put the idea into a person’s head.

Myth
People who talk about suicide just want attention.

Fact
Talking about suicide is a warning sign. Warning signs should be listened to.

Myth
If you promise to keep someone’s suicide plans a secret, you should always keep that promise.

Fact
You should never promise to keep suicide plans a secret. Telling you about the plan can be a cry for help.

Myth
People who attempt suicide and survive never try again.

Fact
Many people who complete suicide have attempted in the past – in fact this is a serious sign that a person may try again.

Myth
If a person wants to complete suicide nothing can stop it happening.

Fact
The young person rarely wants to die, what is wanted is for the pain to stop.

Myth
A sudden improvement means everything is getting better and the danger time for the person to complete suicide is over.

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**Fact**
It could be the complete opposite. It could mean that the person has made a final decision to complete suicide and feels better because of being closer to ending the pain.

**Myth**
Most suicidal people never ask for help. The suicide happens without warning.

**Fact**
Many young people ask for help from friends or see their doctor before attempting suicide. They may not ask for help directly but a person who recognises the warning signs is more likely to able to help.

**Myth**
The only people that can really help are psychiatrists.

**Fact**
There are many people who can help. Most important are family and friends.

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**HAS SOMEONE YOU KNOW COMPLETED SUICIDE?**

If you have lost someone close to you through suicide you are likely to go through a range of strong feelings of grief, or even feel that it could happen to someone else you know or to yourself. A wide range of reactions are normal, remember that these will pass.

- Shock at the death.
- Reliving the memory.
- You might feel numb, or perhaps have a sense of disbelief.
- You might feel very angry about the pain that the suicide has caused to other people.
- You may think you hear or see the person or feel his presence.
- You might search for reasons to answer why this has happened. Often people who complete suicide have an illness called depression that changes chemicals in the brain and makes people think differently, believing there is no hope. They could also have an illness called psychosis.
- One of the strongest and possibly harmful emotions is guilt, perhaps thinking that there might have been something you could have done or should have noticed. Although there are some warning signs, we don't all know them. Not all suicides can be prevented. It was not your responsibility.
- You may feel guilty because of conflict in the relationship with the person who has died.
- People can feel angry and put blame on others. Anger is part of the healing process and helps deal with the guilt and sadness. It may help to talk about it, write about it or use the energy from the anger in a positive way eg walking or sport.
- You could feel the person didn't love you any more and left you, and feel hurt and rejected. In fact the suicidal person was probably so absorbed with his own pain all he wanted was for that to end.
- People sometimes feel shame about the way the person died because of society's beliefs about suicide. This changes from culture to culture depending on how that culture looks at suicide.
- You may be sad that you didn't get to say goodbye. There are other ways to say goodbye. Do something that is meaningful to you or you may want to do something else positive in their memory. Maybe friends will want to share this with you.
- You could grieve for the lost relationship.
- You may even feel some relief especially if the person had attempted suicide several times in the past and you had been dealing with their pain for a long time.
- You could lose trust in people especially close relationships because of the secrecy of the suicide.
- You may find you're avoiding people or they are avoiding you because of the difficulties in some cultures in talking about death and suicide. Try to keep in contact with your friends for the support you can give each other.
- You could feel moody – OK one day, sad or irritable the next.
- You may be afraid that you'll attempt suicide. This is normal and will pass. It is important to find support and talk to friends, family or a trained counsellor.
- You will need support yourself, don’t isolate yourself from friends and family. Let them know what you need. Trained counsellors are also available for support. See Resources below.

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**EFFECTS OF ATTEMPTED SUICIDE**

Not all attempts at suicide end in death. Although many people complete suicide in Australia, there are many, many more than that who attempt suicide. Sometimes this can have devastating effects. There can be permanent physical injury such as damage to body organs like the liver, damage that will affect movement,
cause brain damage or paraplegia. All of these have their own symptoms of pain in addition to the pain that caused the suicide attempt in the first place.

RESOURCES

- Kids Helpline
  1800 55 1800 (free call for young people in Australia).
- Lifeline
  Telephone 13 11 14 (cost of a local call anywhere in Australia).
- ReachOut, a suicide prevention site
  www.reachout.com
- Beyondblue, the national depression initiative (Australia)
  www.beyondblue.org.au
  - Youth beyondblue
    www.youthbeyondblue.com
- Blue Pages, Centre for Mental Health Research at the Australian National University
  http://bluepages.anu.edu.au
- Depnet Help for people and their families to understand depression and its treatment
  www.depnets.com.au
- Living is for everyone – suicide prevention in Australia
  www.livingisforeveryone.com.au
- To search for a helpline in your state check out Helplines Australia
  www.helplines.org.au

REFERENCES

- SANE Australia
  www.sane.org/index.php
  - SANE Steps: how to help when someone is suicidal
  - Suicidal behaviour
  - Other fact sheets and podcasts
- Youth beyondblue
  www.youthbeyondblue.com
  - Fact sheet 14, Suicide – knowing when to get help

FURTHER REFERENCES

- Appleby, Margaret and Condonis, Margaret (1990). Hearing the Cry: Suicide Prevention, Rose Education Training and Consultancy, Narellan, NSW.
- Martin, G, Clark, S, Beckinsale, P, Stacey, K, and Skene, C


The information in this article should not be used as an alternative to professional care.
If you have a particular problem, see a doctor, or ring the Youth Healthline on 1300 13 17 19 (local call cost from anywhere in South Australia).

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Women’s and Children’s Health Network, South Australia (2012).
SUICIDE AND MENTAL ILLNESS
A FACT SHEET FROM BETTER HEALTH CHANNEL

Around 2,000 Australians die from suicide each year and there is no doubt that depression is a major cause. Of those who have killed themselves, many have experienced depression or bipolar disorder. For every person who dies from suicide, at least another 30 people attempt suicide.

Suicide is a leading cause of death for people seriously affected by mental illness. Up to one in 10 people affected by mental illness kill themselves. With medical intervention, counselling, social support and time, however, many of those who have attempted suicide, or who have seriously thought about killing themselves, will go on to live full, productive lives.

An early warning sign of mental illness
A suicide attempt may be an early warning sign that a person is developing a mental illness. If this is the case, it is important to seek assessment and treatment for the person.

Risk factors for suicide
Contributing factors to suicide may include:
• Depression – many people who suicide have experienced depression. This may be the result of another mental illness.
• Psychosis – some people suicide because they are confused as a result of their hallucinations or because they want to get away from the symptoms.
• Drugs and alcohol – misuse of marijuana, heroin, amphetamines and alcohol is closely related to suicidal behaviour.

Suicide warning signs
The majority of people who suicide give warning signs about their intentions. Some of the warning signs are:
• Expressions of hopelessness or helplessness
• An overwhelming sense of shame or guilt
• A dramatic change in personality or appearance, or irrational or bizarre behaviour
• Changed eating or sleeping habits
• A severe drop in school or work performance
• A lack of interest in the future
• Written or spoken notice of intention to commit suicide
• Giving away possessions and putting their affairs in order.

What to do if a relative or friend threatens suicide
If you think a friend or relative is at risk, discuss your concerns with them openly and non-judgementally. Also discuss your concerns with relevant professionals – for example, their doctor or a school counsellor. If someone you know is at serious risk of suicide, keep the phone number of a crisis service (such as Lifeline) handy in case you need urgent help.

After a suicide attempt
If the person has attempted suicide, a doctor or mental health professional in your area can provide education and support. It is important to realise that responsibility for an action ultimately lies with the person who carries it out. This can be hard to accept. However, if everything possible has been done and someone is still seriously determined to end their life, it can be very difficult to stop them.

If you have suicidal thoughts
It is very important to remember that thoughts about harming yourself or suicide are just thoughts. They do not mean you have to actually harm yourself.

There are a number of ways in which you can tackle suicidal thoughts:
• Tell your doctor or other sympathetic people. If your thoughts are associated with depression, delusions or other symptoms, a change in medication and treatment may help get rid of them.
• Keep a list of people you can telephone as well as the numbers for Lifeline and similar services. Make an agreement with one or more people that you will call them if you actually plan to attempt suicide.
• Remember you do not have to act on suicidal thoughts and that they will pass in time.

Where to get help
• SANE Australia Tel. 1800 18 SANE (7263)
  – Need Help? Chat live with a SANE Helpline Advisor (Available Monday-Friday, 9am-5pm AEST).
• Lifeline Tel. 13 11 14
• Kids Helpline (for children aged under 18) Tel. 1800 55 1800
• Your doctor, for information and referral

Things to remember
• Suicide is a leading cause of death for people seriously affected by mental illness.
• Depression is a major cause of suicide.
• Thoughts about harming yourself or suicide are just thoughts and do not mean you have to actually harm yourself.

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IDENTIFYING RISK FACTORS AND WARNING SIGNS FOR SUICIDE

Suicide is rarely the result of a single event or factor but can be understood as a complex interplay of biological, psychological and environmental factors that leave a person feeling desperate and hopeless about life. Following is school support advice from headspace.

Most people with suicidal thoughts do not actually want to die. However, they often can’t see a way out of the problems they are facing and view suicide as their only option.

Assistance for a young person who is considering suicide but feeling confused or ambivalent about their thoughts can help them find answers to the problems they’re struggling with and give them a sense of hope for the future.

While we can never be sure who will attempt to take their own life, knowing the risk factors and warning signs can help us to identify and assist those young people who are most vulnerable.

RISK FACTORS FOR SUICIDE

Research shows us that a wide range of biological, psychological and social factors are associated with an increased risk of suicide. Risk factors can be things that can change (such as substance abuse) or things that cannot change (a family history of suicide).

Undiagnosed or untreated mental illnesses are the most common risk factor for suicide. Research estimates that 90 per cent of people who suicide have a mental illness at the time of their death. Illnesses such as depression, anxiety, bipolar disorder and substance abuse are often associated with suicide in young people.

These illnesses can cause changes in a young person’s thinking, behaviour and functioning, and also increase their feelings of hopelessness and helplessness. This can then lead to thoughts about suicide.

Knowing whether a young person has any of these risk factors can help identify vulnerable young people. However, possessing risk factors does not necessarily mean a person has had – or will ever have – suicidal thoughts. Suicidal thoughts and actions are often a consequence of a range of factors, including past and current experiences, level of social connectedness, coping style and trigger events, such as a relationship break-up or the death of a loved one.

Stressful life events can trigger suicidal thoughts and actions in young people with background risk factors. However, some young people will develop suicidal thoughts without having any previously identified risk factors at all. It’s important to keep in mind that while most young people cope well with stressful or traumatic events in their lives and do not become suicidal, watching out for common warning signs can help us to identify those that may not be coping so well.

WARNING SIGNS OF SUICIDE

Warning signs are the behaviours and noticeable changes that may indicate that a young person is thinking about or planning suicide. Knowing the warning signs for suicide can help us to recognise those at risk. Risk factors and warning signs are cumulative. The greater the number of risk factors and warning signs, the more likely the young person is to be at risk.

Behaviours which may indicate that a young person is at imminent risk of suicide include:

- Threatening to hurt or kill themselves
- Planning ways to kill themselves and/or trying to access the means to kill themselves
- Talking or writing about death, dying or suicide;

Risk factors for suicide include:

- Experiencing mental health problems
- Being male
- Experiencing family difficulties or violence
- Substance abuse
- A family history of suicide
- Loss of a friend or family member
- Social isolation
- Geographical isolation and
- A past suicide attempt.

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Suicide Prevention Issues in Society | Volume 377

• Expressing feelings of hopelessness or worthlessness, that life is not worth living
• Engaging in reckless or risky behaviour without concern for their safety
• Talking or writing about being a burden to others
• Increasing their use of drugs or alcohol
• Withdrawing from friends, teachers and family
• Noticeable changes in mood
• Increased levels of anger or agitation
• Taking less care in their appearance (not washing, appearing dishevelled, etc.)
• Giving away possessions, and
• Saying goodbye to loved ones.

While it is not uncommon for young people to display one or more of these behaviours at various times, especially in times of stress, it is always best to act safely and to talk to the young person as soon as possible about what is going on for them and whether they are having thoughts of suicide.

**RESPONDING TO WARNING SIGNS**

If you are concerned that a young person might be having suicidal thoughts or planning to take their life, then it is important to act immediately and to take what they say seriously. Ask them directly about whether they are having thoughts of suicide and if they have a plan for how they will do it. This will not “put thoughts into their head” and is vitally important in assessing their risk of suicide.

If you believe a young person is at imminent risk of attempting suicide, it is important to seek professional support from your local mental health service or emergency department and to keep the young person safe until help arrives.

Remove any means of suicide available to them in the immediate vicinity, such as medications or weapons. Stay with them (or arrange for someone to supervise them) until they can be seen and assessed.

**ACKNOWLEDGEMENTS**

- South Australia Department of Education and Children’s Services, Catholic Education South Australia and Association of Independent Schools. (2010). *Suicide Postvention Guidelines: a framework to assist staff in supporting their school communities in responding to suspected, attempted or completed suicide*. South Australia: Government of South Australia, Department of Education and Children’s Services.

For more information on suicide or support and assistance visit headspace.org.au/schoolsupport or headspace.org.au

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RECOGNISING SUICIDE WARNING SIGNS

Someone who is thinking about suicide will usually give some clues or signs to those around them that show they are troubled. Suicide prevention starts with recognising these warning signs and treating them seriously, according to SuicideLine.

The following is a list of signs that people might give when they are feeling distraught and overwhelmed, in order to communicate their distress to others. These physical changes and behaviours are indicators that a person might be thinking about suicide.

Some of these signs are stronger indicators that a person may be contemplating suicide – these indicators have been bolded. It is likely that a suicidal person will display a combination of these signs rather than one single sign.

**Physical changes**
- Major changes to sleeping patterns – too much or too little
- Loss of energy
- Loss of interest in personal hygiene or appearance
- Loss of interest in sex
- Sudden and extreme changes in eating habits – either loss of appetite or increase in appetite
- Weight gain or loss
- Increase in minor illnesses.

**Behaviours**
- Alcohol or drug misuse
- Fighting and/or breaking the law
- Withdrawal from family and friends
- Quitting activities that were previously important
- Prior suicidal behaviour
- Self-harming
- Putting affairs in order e.g. giving away possessions, especially those that have special significance for the person
- Writing a suicide note or goodbye letters to people
- Uncharacteristic risk-taking or recklessness (e.g. driving recklessly)
- Unexplained crying
- Emotional outbursts.

**Conversational signs**
- No future – “What’s the point?”
- Things are never going to get any better”
- Guilt – “It’s all my fault, I’m to blame”
- Escape – “I can’t take this anymore”
- Alone – “I’m on my own ... no one cares about me”
- Damaged – “I’ve been irreparably damaged ... I’ll never be the same again”
- Helpless – “Nothing I do makes a bit of difference, it’s beyond my control”
- Talking about suicide or death
- Planning for suicide.

**Feelings**
- Sadness
- Anger
- Shame
- Desperation
- Disconnection
- Hopelessness
- Worthlessness
- Powerlessness
- Loneliness
- Isolation.

**RESPONDING TO WARNING SIGNS OF SUICIDE**

Speak up if you are worried

Talking to a friend or family member about their suicidal thoughts and feelings can be extremely difficult. But if you’re unsure whether someone is suicidal, the best way to find out is to ask.

You might be worried that you might ‘put the idea of suicide into the person’s head’ if you ask about suicide. You can’t make a person
suicidal by showing your concern. In fact, giving a suicidal person the opportunity to express his or her feelings can give relief from isolation and pent-up negative feelings, and may reduce the risk of a suicide attempt.

**How to start a conversation about suicide**

- I am worried about you because you haven’t seemed yourself lately.
- I have noticed that you have been doing (state behaviour), is everything OK?

**Questions you can ask**

- What can I do to help you?
- What supports have you called on so far?

**What you can say that helps**

- I want to help you and I am here for your when you want to talk.

**ASSESS THE RISK**

If someone you know tells you that he or she is thinking about suicide, it is vital to evaluate the risk. People who are at the highest risk in the immediate future have the intention to end their life, a specific plan, the means to carry out the plan and a timeframe.

**Go through the following questions with the person**

1. Do you intend to take your life? (INTENTION)
2. Do you have a plan to take your life? (PLAN)
3. Do you have access to the means to carry the plan out? (pills, gun, etc) (MEANS)
4. Do you have a timeframe for taking your life? (TIMEFRAME)

If they are at high risk of suicide, seek immediate help by calling 000 (police, ambulance), or with their permission take the person to the emergency department of the nearest hospital.

**Know where to go for support**

Find out what services are available. This should include local emergency services, community health services and hospitals.

Keep a list of contact details and times when the services are available. You can look up local services at our community services database, JIGSAW, [http://jigsaw.ontheline.org.au](http://jigsaw.ontheline.org.au)
WHAT WORKS IN SUICIDE PREVENTION?

If suicide was a disease, funds would be scrambled and urgent searches started to find vaccines, causes and cures. No part of our community is immune; suicide kills more young people than anything else and kills three times more men than women. The suicide rate is highest in those aged over 85. Following is an overview from the National Mental Health Commission

Suicide takes one and a half times as many Australian lives each year as road accidents. Road accident deaths have substantially reduced in recent decades, but over the same period there has not been the same level of reduction in suicide rates. We can and must do better than this.

We all know that drink driving increases our risk of dying on the road and discussing who will be the designated driver is often part of a night out. We need the same openness with our other conversations.

Talking about difficult emotions – even if we notice someone isn’t coping – does not come easily to many of us, and suicide is still often a taboo subject.

Every death by suicide expresses unimaginable anguish, and it happens on average six times every day in Australia. In 2007 over 65,000 people reported attempting to take their own life.

Most of these attempts do not come out of nowhere. Many of these 65,000 people would not live their life in isolation – they may attend school or work (or fail to turn up), talk with friends or family, visit their GP or Centrelink – or they may simply ‘fall off the radar’.

In our 2012 Report Card we called for more timely support for those who may be contemplating suicide, and more rapid and local reporting of suicidal behaviour. We repeat this call, and will continue to do so as long as there is no visible action and preventable suicides continue to occur.

This year we focus on what can drive down our suicide rate and the number of suicide attempts each year. We highlight where our knowledge is lacking in what works best for the community as a whole, and for groups who are more vulnerable to suicide. We look at the geographic, social and economic inequality of the burden of suicide across our communities and shine a light on the troubling level of suicide attempts.

WHAT WE KNOW

We know that each year in Australia, more than 2,200 people die by suicide, and that an overwhelming three quarters of these are men. The decade between 2002 and 2011 saw a 15.3 per cent reduction in suicides, mostly due to a substantial reduction in high levels of deaths among young men. Declines across all groups appear to have stalled in the last few years. Recent changes in data collection methods and review may have contributed to this picture, but it is clear that rates remain too high.

We know that suicide arises from a complex interaction of many vulnerabilities, triggers and factors in a person’s life. However, suicide is not just an individual act. Social and economic circumstances and differences between cultures also contribute.

We know this because it hits our disadvantaged and marginalised communities the hardest, reflecting wider social, geographic and economic inequalities as well as everyday discrimination and exclusion.

In our consultations the Commission has been made aware of how suicide affects people in their communities – those at higher risk of suicide include Aboriginal and Torres Strait Islander peoples; those who identify as...
lesbian, gay, bisexual, transgender or intersex (LGBTI); those experiencing chronic physical pain or illness; some armed forces veterans; men who live in rural or remote areas; and people experiencing mental illness.

Aboriginal and Torres Strait Islander people who die by suicide are half as likely as other Australians to have ever received help for a mental health problem. But they are twice as likely as non-Indigenous people to take their own lives.

The suicide burden falls disproportionately on young Aboriginal and Torres Strait Islander men and women – where those aged between 15 and 19 years die by suicide at 4.4 and 5.9 times the rates of other young Australians respectively.

There are stark geographical inequalities in suicide rates which this year we show for the first time. Rates are more than twice as high in the Northern Territory (20.0 per 100,000) as in New South Wales and Victoria (8.5 and 9.5 per 100,000 respectively). The map of suicide deaths in Australia at Figure 15 shows this regional variation for the period 2007-2011, with darker colours indicating a higher rate of deaths. People living in non-metropolitan areas are more likely to die by suicide than those living in capital cities, and we know that men not living in major cities are almost twice as likely as their urban counterparts to die by suicide.

Suicidal thinking, plans and attempts among the LGBTI community are shockingly high. People who identified as lesbian, gay or bisexual reported suicidal thoughts during their lifetime at almost three times the rate of those identifying as straight, and suicidal plans or attempts during their lifetime at four times the rate.

Experiences of discrimination and social exclusion, which contribute to poor self-esteem, isolation, and mental health problems, are behind these high rates.

Some life experiences appear to leave some people at increased risk of suicide. For example, although the rate of suicide among serving defence force personnel is reported as being slightly lower than the general population, the risk of suicide is found in some studies to rise over time for armed forces veterans. There is international evidence that those who have experienced severe psychological or physical trauma during war have an increased risk of suicide.

Experiencing chronic pain or illness are also related to risk for suicide. Recent research in the UK has found that ten per cent of people completing suicide were...
suffering chronic illness. In ‘battling’ the physical illness a person’s emotional wellbeing can be overlooked by family, friends and their treating health professionals; for example, as many as 70 per cent of those diagnosed with cancer think about suicide during the three months after diagnosis.

“Due to actual experiences of discrimination and an expectation of discrimination by lesbian, gay, bisexual, transgender and intersex people (LGBTI), suicide and thoughts of suicide are a high risk.”

Susan Ditter, Working It Out Tasmania

WHAT THE EVIDENCE SHOWS IS GOOD PRACTICE

There is surprisingly little evidence about what works in suicide prevention.

A message is emerging from recent reviews of research: there is an overall lack of evidence, but there are a handful of effective single interventions to reduce the risk of suicide. These interventions can be divided into: those aimed at the whole population (universal); those aimed at ‘at-risk groups’ (targeted); and those for people experiencing mental health problems.

We are encouraged that initiatives funded under the National Suicide Prevention Program are being evaluated, and this will provide us with much-needed Australian evidence about effective approaches. In the meantime we know that there are several examples of international best practice in this country.

Our literature review of international and Australian research published in the last three years shows that the most effective programs are those which are comprehensive and systemic and which incorporate multiple but co-ordinated approaches and interventions. However, there is as yet little knowledge about how different elements of these systemic approaches interact with each other, how they might be best integrated, nor about how different combinations of approaches work in different settings.

A good suicide prevention approach is not just, or even mainly, about mental health services. Many other agencies and places – Centrelink, homeless shelters, schools and colleges, and workplaces – are far more likely to come into contact with people who are suicidal. In a Queensland study, 63 per cent of those who have survived a suicide attempt report that they have not attended any mental health service or professional. Such low contact with mental health services is repeated in other countries.

Preventing suicide requires action at all levels of government (to plan, prioritise resources, and co-ordinate), services (to identify and target those most at risk), and communities (to drive ‘grassroots’ responses). The European Alliance against Depression, active in 17 European countries, is one example of a multi-component intervention which has had a positive impact on suicidal behaviour (but less impact on suicide rates). The four main components are: GP education, public relations activity, training of community facilitators and interventions targeted at high-risk groups. Grassroots community networks and community capacity building in suicide prevention deliver this approach.

Joining up local interventions across agency and service boundaries seems key to effective prevention. The Baerum suicide prevention team in Norway achieves effective community follow up after discharge from hospital after a suicide attempt through a model called ‘chain-of-care’. Such a model of joined-up support could be extended to alcohol, primary care and other services to encourage them to collaborate in helping those vulnerable to suicide.

For those communities more vulnerable to suicide, targeted interventions are needed. We can see the importance of such a tailored approach which is designed by and with – not for – community members when we look more closely into what is known about effective approaches for suicide prevention among Aboriginal and Torres Strait Islander peoples.

“Support when my dad suicided and support being a carer would have made a huge difference. I was unwell myself and had to care for my children and my very unwell mum.”

FIGURE 15: SUICIDE DEATHS IN AUSTRALIA 2007-2011

Based on ASGS Statistical Area 4.
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WHAT WE DON’T KNOW

Where we need more evidence and to shine a light

Suicide is often described as being ‘in the shadows’, ‘hidden’, or ‘silent’. The true prevalence of suicide, how to reliably predict it, and how to best prevent it are also largely hidden from our view.

Suicide research focuses on the epidemiological study of prevalence and risk factors. We are lacking qualitative work with those bereaved by suicide, who experience suicidal thoughts, or who have gone through a suicide attempt. Accessing in a sensitive way this lived experience is a research priority, if we are to better understand what helps and what doesn’t. It is a priority which may be jeopardised by the preoccupation with risk of many research ethics committees.

Even basic information about rates of suicide is difficult to know accurately, because of differences in reporting standards, difficulty determining intent, delays in Coronial verdicts, and insurance- and stigma-related barriers. Australia is currently attempting to standardise suicide reporting across the country. Without this, we cannot know whether interventions have had any positive effect.

There is no assessment tool or known constellation of risk factors which can reliably predict the likelihood that someone will take their own life.

In terms of what works for suicide prevention, we are only just starting to scratch the surface. We do not know the impact of our National Suicide Prevention Strategy, for example, on suicide rates.

One particular aspect of implementation which we instinctively know would help is continuity of care and follow-up. This deficit in our current systems has been emphasised in the highest level inquiries and policies. This work recognises the need for collaboration between...
government departments, levels of government, local service providers from health, education, justice, housing and employment, and service planners and people at risk.

We are far from having an integrated system of prevention backed up by standards, evaluation and monitoring to provide:

- Community-level understanding of warning signs
- Clear and easy access points for help, and
- A ‘seamless service’ for those at risk of suicide or who have attempted suicide.

Part of the problem is that our suicide prevention policies and strategies currently do not offer any sense of what interventions should be prioritised. We have a fragmented system made up of isolated programs running in parallel. This approach does not catch people falling through the ‘gaps’ between services or ensure they access help in the first place.

One solution has been proposed by leading Australian suicide researchers, who recommend widespread implementation of the few proven prevention approaches, alongside small-scale piloting and evaluation of innovative approaches.

WHERE THE COMMISSION IS LOOKING FOR CONTINUOUS IMPROVEMENT

The Commission wants to see improvement in four key areas in suicide prevention. These are all related to the need for greater understanding of effective ways to reduce the rate of suicidal behaviour and death from suicide.

First, there must be increased funding for research and implementation efforts in line with the burden of disability, suffering, and potential years of life lost to suicide. A recommendation of the 2010 Senate Inquiry into Suicide in Australia recommended a doubling of national suicide prevention program funding and that future increases on top of this be informed by research. The Commission agrees that where we spend money must be based on mandatory and continuous assessment of outcomes. This would form the basis of cost-effectiveness estimates and policy prioritisation.

A second priority is the development of published standards for prevention activities and joined-up support for those experiencing suicide attempts or bereaved by suicide. Such quality standards exist, for example, in Ireland, which may provide a model for Australia to follow. These should be accompanied by a national monitoring and accountability mechanism, recognising that reducing the suicide rate is the responsibility not just of health services but of whole communities.

Thirdly, we need basic infrastructure development to enable us to better assess – in a timely way – the extent and pattern of the problem, and changes over time. Steps towards this are underway; work has commenced on a Victorian Suicide Register to collate detailed information on all Coroner-determined and suspected suicide deaths since 2000. This follows the Queensland Suicide Register which was established in 1990 as the first of its kind in the Asia-Pacific region. Establishing suicide registers with consistent data throughout Australia would be of considerable value.

Fourthly, in line with our philosophy of a contributing life, the Commission would like to see exploration of what a whole-system suicide prevention and response framework would look like. How can we get agencies which historically work in silos to work together to bridge the gaps fallen into by those vulnerable to suicide? We know so little about how to encourage collaboration to provide person-centred support.

The Commission believes that it is unacceptable that every year, more than 2,200 people lose their lives to suicide. In addition, the hidden suffering represented by the 65,300 people who report a suicide attempt each year is staggering. While we can be shocked at this data, we must not forget that behind each number is a person who feels locked into a hopeless situation.

We have emphasised that suicide is an important public health problem. Given this, it is surprising that there is so little evidence about what works in preventing it. We acknowledge that there are no simple solutions to such a complex issue. However, work must continue to bring suicide rates down and to bring the same level of consciousness to the issue as has been seen for drink driving.

Research released by the National Mental Health Commission has found that Australians feel they lack the most basic knowledge of mental illness, and that many ‘don’t know a single sign to look out for’.

The report, titled ‘Can we talk ... about mental health and suicide’, is based on informal group discussions around Australia which set out to recreate the conversations Australians are having about mental health and suicide at home, at work and with their friends.

National Mental Health Commissioner Janet Meagher says the study reinforces that while we have stories to tell, we are still struggling to make sense of mental illness and suicide.

“Around one in three Australians will experience a mental health difficulty at some stage in their lives, and when alcohol and drug-use disorders are included, this rises to close to one in two. However, we know that less than half of those Australians who experienced symptoms of mental illness in the past year actually consulted a health service.

“This study highlights that the stigma associated with accessing the mental health system is still one of the biggest barriers to treatment. We need to do better as a society to support people who need help. We can start by making mental health services a much higher priority for governments, and in the community,” she said.

No single culture deals with mental illness and suicide well, according to the people who participated in the study. However, Australian culture is singled out for criticism for discouraging open and forthright communication and for a loss of community connectedness. Respondents of both sexes also agreed that there is a gender divide when it comes to talking about and seeking treatment for mental health difficulties (that is, men are less likely to talk about their problems or to seek help).

According to the study, suicide provokes strong, sometimes contradictory, emotions and reactions – and judgemental phrases permeate the language of many Australians. The research also found that whether someone is forgiving or judgemental in their outlook seems to turn on the degree to which they hold the individual, or their family, responsible for their condition (i.e. as a result of their genetic tree, mistreatment or neglect; or whether they contributed to its onset through their own folly due to drugs or other risky behaviour).

“Around one in three Australians will experience a mental health difficulty at some stage in their lives.”

“We need to talk more about mental illness and suicide, and treat it as we would any other illness – as something that can affect anyone at any time. We need to make it okay for people to ask for help, and make it easier for people to talk to friends, family members or colleagues about how they are feeling,” Commissioner Jackie Crowe said.

A number of participants in the study said they felt that Australia is in the midst of an epidemic of mental illness and suicide, while highlighting that if a health issue isn’t in the media, it can feel as if it doesn’t exist.

“This research was commissioned to provide insight into how we perceive and deal with mental health issues. Hopefully it can contribute to a more informed discussion on mental health difficulties and suicide prevention, that helps make these issues a priority for all Australians,” Commissioner Crowe said.

Other key findings from the research:
• We don’t know how to respond to mental health difficulties – we’re at a loss for how to help. Our knowledge of ‘the system’ and treatments available is also out of date and stuck in cliché.
• There are strong cultural forces which discourage us from discussing and disclosing mental illness and suicide (e.g. traditions, social norms, workplace culture etc), and families are tending to keep mental health difficulties and suicide ‘in the closet’.
• Several participants said, “it’s easier to talk to a stranger”. While helplines can fulfil one aspect of this important function by providing information and advice, people are reluctant to use them as they don’t want to divert resources from people in real crisis.
• To suspend judgement, we need to walk in another’s shoes. The stories of people who have experienced mental illness can go a long way toward demystifying how mental health difficulties arise, and changing attitudes.

See the next page for the key findings and implications from this report.
Key points and implications

Summary information from the National Mental Health Commission report, ‘Can we talk ... about mental illness and suicide?’

**KNOWLEDGE AND BELIEFS**
- Australians say that they lack the most basic knowledge of mental illness, leading some of the people who participated in this study to say that they ‘wouldn’t know a single sign to look out for’. While our mothers readily dispense advice and remedies to deal with physical ailments, few offer the same cure-alls for mental difficulties.
- Our daily language is replete with references to mental illness – stress, anxiety and depression to name a few. By overusing some terms and phrases in everyday life which have a clinical basis in reality, we run the risk of trivialising and therefore failing to recognise the signs of what are serious medical conditions. There is almost a normalising, desensitising effect when diagnostic phrases like “I’m really depressed” or “I’m anxious” are repeatedly used to describe routine frustrations and emotions.

**ATTITUDES**
- While many individuals espouse open-mindedness, others hold onto judgemental and, in some cases, bigoted views toward mental illness. Whether someone is forgiving or judgemental in their outlook seems to turn on the degree to which they hold the individual, or their family, responsible for their condition; whether they inherited it through their genetic tree or were the victim of mistreatment and neglect; or whether they contributed to its onset through their own folly due to drugs or other risky, wayward behaviour. How people feel and think about suicide is very personal, based on their own experience and exposure, world views and fears. In this sense, there is no right or wrong when it comes to how people feel about it. While we might concoct and contrive theories to try to rationalise the irrational, it is simply not possible to know what goes on in the mind of the would be or actual suicide. However, judgemental phrases permeate the language of many Australians.

**BARRIERS TO COMMUNICATION**
- Both sexes wholeheartedly agree that there is a gender divide when it comes to talking about and seeking treatment for mental health difficulties. Many men incorrectly interpret mental illness as a challenge to their masculinity and identity as a husband, father and provider and in their role in their community and society at large. Older men are the first to acknowledge that they suffered as a result of the silence and stigma that surrounded mental illness when they were younger.
- No single culture deals with mental illness and suicide well, according to the people who participated in this study. However, Australian culture is singled out for criticism (along with the rest of Anglo-Celtic culture) for discouraging open and forthright communication and for a fracturing and loss of community connectedness. Insisting that men ‘just soldier on’ or use alcohol or drugs to deal with problems instead of talking is also seen as an unhealthy trait of Australian culture.

**BARRIERS TO TREATMENT**
- Simply accessing the mental health system can be difficult. Not only are we unsure about where to go for help, the stigma associated with accessing the mental health system can be one of the biggest barriers to treatment.
- Australians say that they are wary of mental health professionals because they fear they will be prescribed psychoactive drugs before other avenues of treatment are fully explored. In particular, they fear that they will become dependent on these drugs for the rest of their lives and experience potentially dangerous side effects.
- Australians criticise our approach to mental health and mental illness as just being about ‘fixing problems’. On the continuum which represents mental health at one end of the spectrum and mental illness at the other, there was a sense that in order to build resilience and maintain mentally healthy citizens, we may need to focus instead on prevention rather than an unequal weighting on the cure.

**ENABLING COMMUNICATION, ENABLING TREATMENT**
- Mental illness is an embarrassing subject for many of us, whether we are confiding in a friend or consulting a doctor. However, the embarrassment is diminished when the relationship to the person assisting is an impartial one. For these reasons, several participants said, ‘it’s easier to talk to a stranger’. While helplines can fulfil one aspect of this important function by providing information and advice, people are reluctant to use them for routine enquiries; they don’t want to divert precious resources from people in real crisis.
- Some people believe that we are in the midst of an epidemic of mental illness and suicide. Given that simple advice can help stem the tide of some diseases and conditions, participants suggested that Australia should mount a public education campaign, ‘like the one we had with AIDS’. After all, in the information age, if a health issue isn’t in the media, it doesn’t exist.

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Suicide prevention in Australia is often represented as, first and foremost, about recognising and getting help and treatment for depression. Everywhere, we are given the message that depression leads to suicide. A search of suicide prevention websites, media reporting, and popular debate turns up repeated calls for awareness about depression.

Suicide is the culmination of complex interactions between biological, social, economic, cultural and psychological factors operating at individual, community and societal levels.

There’s no doubt that mental illness, especially depression, is a risk factor for suicide. Researchers estimate between 30 per cent to 90 per cent of people who die by suicide have some form of mental illness.

But those estimates also tell us that many people who take their own lives are not mentally ill. Life history and personal circumstances – such as relationship breakdowns, business failure, or unemployment – can play a strong role in the development of suicidal behaviour, irrespective of whether or not that behaviour is accompanied by mental illness.

Suicide is the culmination of complex interactions between biological, social, economic, cultural and psychological factors operating at individual, community and societal levels.

Simply treating mental illness, without addressing the context in which illness has occurred, does not necessarily prevent suicide. Or, as one experienced mental health nurse put it in a conversation with me:

A patient of mine rang and said “that’s it, the antidepressants aren’t working anymore, I can’t go on”... I’d known him for a while and I said, “what else is going on?”

Turns out that what had really got to him was his business was finally picking up, but he couldn’t afford to hire the workers he needed to get the jobs done... his suicidal thoughts didn’t come from depression, they were because some practical things needed to happen, and he couldn’t make them happen.

Connections between mental illness and suicide vary across different demographic groups. Among younger people, for instance, suicide is often linked with school, family, or relationship problems, rather than psychiatric illness.

Simply treating mental illness, without addressing the context in which illness has occurred, does not necessarily prevent suicide.

There are also cultural differences at play: while mental disorders are often associated with suicides in European and North American people, this is not the case in Asia. Varied cultural understandings of mental illness may contribute to part of this difference – but they cannot explain all of it.

Why such a heavy focus on mental illness?

Millions of research dollars have gone towards exploring connections between mental illness and suicide. So when we address mental illness, we are trying to take evidence-based action that can reduce one important risk factor for suicide.
Unfortunately, the relentless focus on depression means we have less research evidence around other contributors to suicide than we do for mental illness. We have created a cycle where we focus on mental illness because we know it relates to suicide, and we know it relates to suicide because we have focused on it.

As a result, suicide prevention programs are typically administered through mental health branches of health departments. Suicide prevention policies are often ‘tacked on’ to mental health policies. Other risk factors and contributors to suicide get a mention, but they are generally relegated to the sidelines.

Framing suicide within a medical model oversimplifies an incredibly complex human behaviour.

This in turn makes it difficult to develop rigorous preventive strategies that step outside an ‘interventionist’ medical model, in which suicide is seen as the result of illness.

Framing suicide within a medical model oversimplifies an incredibly complex human behaviour. Focusing on mental illness helps us feel that we are doing something about the ‘wicked problem’ of suicide, but in practical terms it can mean people at risk of suicide may not get the ‘right’ information or the ‘right’ types of help.

There is also the risk of misdirecting scarce resources. For instance, although awareness campaigns are often held up as a suicide prevention measure, we have no direct evidence that years of government-funded depression awareness campaigns have impacted on Australian suicide rates.

Differentiating suicide from mental illness is not just a theoretical debate. It has tangible implications for suicide prevention strategies. When communities at high risk of suicide are identified, for example, the default response is usually to “send in more mental health services”.

But what if the real problem is financial insecurity and stress, brought on by a failing industry on which a whole community relies? Or entrenched social disadvantage? Or loss and bereavement?

Responding adequately to these suicide risk factors calls for a whole-of-life approach that crosses different sectors, agencies, and actors. Ultimately, achieving real change in this area requires more than lip-service and platitudes. It requires a new paradigm in suicide prevention that places suicide – not depression – at its centre.

Samara McPhedran is Senior Research Fellow, Australian Institute for Suicide Research and Prevention, National Centre of Excellence in Suicide Prevention at Griffith University.

PREVENTING SUICIDE

Everyone has a role to play in preventing suicide. Choices we make today can help prevent suicide, advises Lifeline.

Suicide is the leading cause of death for Australians aged between 15 and 44. Men are four times more likely to die by suicide than women and ABS data (2012) shows more people die from suicide than road deaths. Most people don’t want to die they just want their pain to stop. Everyone has a role to play in preventing suicide. Choices we make today can help prevent suicide.

Are you thinking about suicide?

Get help! You are not alone. Call Lifeline 13 11 14 or 000. Just by reading this, a part of you is looking for ways to live and to get help for problems in your life. It is not uncommon to feel this way and lots of people have suicidal thoughts and are able to work through them and stay safe.

Thoughts and feelings of ending your life can be overwhelming and very frightening. It can be very difficult to know what to do and how to cope, but help is available.

- Contact Lifeline (available 24/7)
- Talk to someone you trust – you don’t have to go through this alone. Tell them how you feel – and that you are thinking of suicide. Ask them to help you keep safe.
- Get help and support to stay alive – contact a helpline, your GP, a counsellor, psychologist or psychiatrist, a hospital emergency department, minister, teacher or anyone you trust to keep you safe.
- If life is in danger – call emergency services 000.

Possible signs someone might be thinking about suicide

Most suicidal individuals give warning signs or signals of their intentions. The best way to prevent suicide is to recognise these warning signs and respond to them.

Situations
- Recent loss (a loved one, job, relationship or pet)
- Major disappointment (missed promotion at work, failed exams)
- Change in circumstances (divorce, retirement, separation, children leaving home)
- Mental disorder/illness
- Physical illness/injury
- Suicide of someone they know or recognise
- Financial/legal problems.

Feelings
- Hopelessness
- Feeling trapped
- Depression
- Irritable/moody, angry
- Worthlessness
- No sense of purpose/reason for living.

Behaviours
- Previous suicide attempts
- Talking or writing about suicide/death, even if it seems to be a joke
- Seeking access to something they can kill themselves with
- Being moody, withdrawn or sad
- Saying goodbye/giving away possessions
- Losing interest in things they previously enjoyed
- Taking less care of their appearance
- Anxiety or agitation, including difficulty concentrating or sleeping
- Engaging in self-destructive or risky behaviour
- Increased use of alcohol or drugs
- Withdrawal from other people
- Sometimes a positive mood after a period of being down may indicate the person has made up their mind to take their own life, and feels relief that the decision has been made.
**What you can do to prevent suicide**

1. **Reach out** – Ask them directly if they are thinking about suicide. It needs to be a direct question that can’t be misinterpreted.
   
   “Are you thinking about suicide?”
   
   Most people with thoughts of suicide want to talk about it. They want to live – but desperately need someone to hear their pain and offer them help to keep safe.
   
   Don’t be afraid to ask them if they are thinking about suicide. This shows you care and they’re not alone.

2. **Listen to them** – Allow them to express their feelings. Let them do most of the talking. They will often feel a great sense of relief someone wants to talk to them about their darkest thoughts.

3. **Check their safety** – If you are really worried don’t leave them alone. Remove any means of suicide including weapons, medications, drugs, alcohol, even access to a car. Get help by calling Lifeline 13 11 14, or emergency services on 000. You can also take them to the local hospital emergency department.

4. **Decide what to do and take action** – Talk about steps you can take together to keep them safe. Don’t agree to keep it a secret, you shouldn’t be the only one supporting this person. You may need help from someone else to persuade them to get help. You can also help by finding out information on what resources and services are available for a person who is considering suicide.

5. **Ask for a promise** – Thoughts of suicide may return, so ask them to promise to reach out and tell someone. Asking them to promise makes it more likely they will tell someone.

6. **Get help** – There are lots of services and people that can help and provide assistance.
   
   - GP (doctor)
   - Counsellor, psychologist, social worker
   - School counsellor
   - Emergency services 000
   - Community Health Centres
   - Crisis support services like Lifeline, Kids Helpline
   - Seek support from family and friends, youth group leader, sports coach, priest, minister or religious leader etc.

   In some situations they may refuse help and you can’t force them to get help. You need to ensure the appropriate people are aware of the situation. Don’t shoulder this responsibility yourself.

**Suicide prevention training**

LivingWorks aims to create suicide safer communities by providing training to increase suicide awareness and prevent suicide.

The training is available to any individual, organisation or community group to:

- Increase their awareness of suicide and see prevention opportunities they may otherwise miss
- Become more alert to clues and communications that someone may be thinking of suicide
- Ask about suicide and respond in ways that show understanding and assess risk
- Work with persons at risk to increase their safety
- Facilitate links with further help from family, friends and professional helpers as needed.

**WHERE TO GO FOR HELP**

- Call 000 if life is in danger
- Contact Lifeline (phone/online)
- Call Kids Helpline (if you are 25 or under)
- Contact your local GP, counsellor or psychologist
- Speak to a friend or family member.

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

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

Each year, in Australia, about 2,200 people die by suicide, according to the ABS Causes of Death reports. This number has remained stubbornly around the same level for the past decade. The ABS National Survey of Mental Health and Wellbeing reports 65,000 attempts of suicide each year. Around 38,000 of these are recorded through interactions in our health system, principally at Accident and Emergency Departments of public hospitals, as reported by the Australian Institute of Health and Welfare. Estimates from research (Botha et al; 2009) are that around 21,000 people throughout Australia are impacted by another’s suicide each year – in the past decade a population the size of Wollongong has grieved the loss of a friend, a brother, a father, a sister, a football team member or a work colleague.

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

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

More recently Professor Thomas Joiner at Florida University developed an Interpersonal Theory of Suicide, drawing on psychological autopsies concerning people who have died by suicide; this model approaches suicidal ideation from...
the perspective of psychosocial factors that influence how a person views themselves and the world around them. These forces may create the notion that suicide is a preferred option – a person comes to the belief that the world will be better off without them.

Additional perspectives on suicide are identified by researchers in the United Kingdom, including Professor Rory O’Connor of University of Stirling, who, in the 2010 International Handbook of Suicide Prevention, present an Integrated Motivational-Volitional Model that shows the inter-relationships between background factors and ‘motivational factors’ which spur a person onto suicidal behaviour.

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

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

**HELPLINES – CRISIS SUPPORT SERVICES**

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

A strong challenge to suicidal thinking, therefore, is the message: “you are not alone”. This is the thinking behind helplines as non-judgemental and accessible services for people to contact when seeking help, with research in Australia and internationally suggesting between 25 and 30% of callers to such services are experiencing suicidal ideation at the time of the call.

It is also the thinking behind community campaigns such as RUOK? Day, which reinforces the power of positive conversation in supporting another’s wellbeing and encourages help-seeking when times are tough, including the promotion of helplines and crisis support services.

**INFORMAL SUPPORTS – FRIENDS AND FAMILIES**

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

**SOCIAL EXCLUSION**

Social exclusion is of particular concern because of the direct attack it can have on a person’s perceptions of ‘belongingness’. Very high rates of suicide amongst populations which are vulnerable to discrimination seem to bear this out: persons of indigenous background are 2.5 times the general population dying by suicide, persons identifying as Lesbian, Gay, Bisexual, Transgender and Intersex are estimated to at least 3.5 times more often die by suicide, persons identifying as Lesbian, Gay, Bisexual, Transgender and Intersex are estimated to at least 3.5 times more often die by suicide, persons identifying as Lesbian, Gay, Bisexual, Transgender and Intersex are estimated to at least 3.5 times more often die by suicide, persons identifying as Lesbian, Gay, Bisexual, Transgender and Intersex are estimated to at least 3.5 times more often die by suicide, persons identifying as Lesbian, Gay, Bisexual, Transgender and Intersex are estimated to at least 3.5 times more often die by suicide, persons identifying as Lesbian, Gay, Bisexual, Transgender and Intersex are estimated to at least 3.5 times more often die by suicide.

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

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

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

**WHAT WE CAN ALL DO FOR SUICIDE PREVENTION**

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

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

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

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

Alan Woodward is Executive Director, Lifeline Foundation for Suicide Prevention.


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Suicide prevention: taking a new approach

The change in our approach to suicide prevention cannot come quickly enough, writes Sue Murray, CEO of Suicide Prevention Australia.

Browsing the titles of Suicide Prevention Australia position papers offers an interesting insight into suicide prevention – it is complex. And it is a complexity that is often overshadowed by a focus on mental health.

Certainly mental health, or rather ill-health has a significant place in many people’s decision to think, plan and take their own life, but it is not the only factor.

Certainly mental health, or rather ill-health has a significant place in many people’s decision to think, plan and take their own life, but it is not the only factor.

This is starkly played out when you line up the topics of our position papers.

• Aboriginal and Torres Strait Islander peoples
• Social inclusion
• Alcohol and other drugs
• Youth
• Men
• Gay, lesbian, bisexual, transgender and intersex communities
• Rural and remote communities
• Chronic illness and pain
• Stigma
• ... and so on.

No one factor can be held to account for the decision a person makes to take their own life. It is this multiplicity of factors that have made it so difficult to gain traction in reducing suicides in Australia. A review of the statistics published by the Australian Bureau of Statistics (ABS) and the Australian Institute of Health and Welfare (AIHW) show us just how hard it has been to make headway in reducing deaths from suicide. They have plateaued. Certainly the effort to focus on the reduction of youth suicide has seen a decline in young people taking their own life and this is extremely laudable. It must also be sustained because every year there is another cohort of young people who are seeking to define their sense of self, face the challenges of gaining an education and securing employment, maintain strong and supportive family structures and stay connected to those who can help in troubled times.

Most surprising, especially for those who have not been working in the sector, is that each year the highest numbers of suicides occur in working age adults, predominantly men aged 35-50 years. Over the last decade some 65-70% of suicides were in people between the ages of 25 and 60 years and four out of five of those people were men. Men who are likely to have young children. Men who are likely to have ageing parents. Men who are likely to supervise younger people in the workplace. All of whom will be affected by his death. The ripple effect is vast and all too often there are many unanswered questions that remain in its wake.

The evidence base in suicide prevention

It is a challenge to determine what works in suicide prevention given that we cannot implement randomised clinical trials and suicide is a relatively rare event. Similarly it is hard to know what would have happened in the absence of any intervention.

However, Suicide Prevention Australia agrees strongly with the World Health Organisation and the National Mental Health Commission that suicide prevention requires an innovative, comprehensive multi-sectoral approach, including both health and non-health sectors, e.g. education, labour, police, justice, and needs to sit above politics, culture and religion.

Reducing suicide rates requires action at the whole population level, targeted interventions in high-risk groups and settings, and appropriate and effective responses to individuals identified at imminent risk of suicide.

Evidence supports strong components across a set of key areas – improved awareness and skills for front line personnel, especially GPs but also police and ambulance services, families, school or work communities; improved mental health care; restricting access to means by which individuals may end their lives; implementing media reporting guidelines to prevent contagion; and maintaining contact with those who have attempted suicide after discharge to significantly reduces risk of further attempts and hospitalisation.

In Australia we currently have a range of new evidence-informed initiatives which offer hope of successful outcomes and should be watched with great interest. These include but are certainly not limited to community plans for preventing and responding to suicide clusters, support for schools affected by suicide, coordinated community response to the bereaved and suicide clusters, support for schools affected by suicide, coordinated community response to the bereaved and various e-health services. And importantly we now have a focus on reducing the toll of suicide on Indigenous communities via the National Aboriginal and Torres Strait Islander Suicide Prevention Strategy.

We are learning a great deal but there remain significant gaps in our knowledge.

Challenges to reducing suicides in Australia

There are so many challenges that face society all requiring legislative, structural and/or social reform if we are to truly see a decline in suicides in Australia.
The mental health system is fragmented and under-resourced. It separates mental from physical health and often attempts to treat the mental illness independent of social, economic, inter-personal and cultural environments. The number, breadth and diversity of suicide prevention services is unknown as is the effectiveness of such programs. There is a lack of quality assurance standards by which individuals, professionals, workplaces and communities can assess programs against needs. Investment is needed to ensure our frontline workforce is sustainable and effective.

There is a lack of political and bureaucratic strategic thinking. Australia’s federated system means resources are not close to the ground in communities where they can most effectively be utilised. It promulgates the ‘blame game’ and provides an easy cop-out from not adequately resourcing suicide prevention programs. Suicide prevention continues to be seen as an adjunct to mental health rather than a cross-sectoral responsibility.

The stigma of suicide has a profound impact on suicide prevention. It contributes to reduced community awareness of the issues related to suicide and suicide prevention.

The voices of people with lived experience of suicide too often go unheard. They, in partnership with the voices of suicide prevention professionals, need to influence the direction and the way in which programs are delivered and suicide is spoken about in communities.

These systemic issues are further compounded by social mores which contribute to a greater risk of suicide. Alcohol consumption which is so ingrained in our culture; a heavily accentuated focus on body image for young people; an ageing population that is increasingly losing their social connections; and ongoing problems with racial and sexual discrimination as well as bullying. These are just a few examples of the many social issues that play a role in suicide.

The stigma of suicide has a profound impact on suicide prevention. It contributes to reduced community awareness of the issues related to suicide and suicide prevention, restricts help-seeking behaviours for people who are suicidal, impacts the resourcing of appropriate services, inhibits the grieving of those bereaved by suicide, and adds to the burden of those with lived experience. Challenging stigma requires confidence in discussing suicide on the public stage yet we still don’t know how to safely and effectively talk about suicide.

Finally we face the challenge of understanding and prioritising where we should need to focus our efforts. What is it that will work most effectively? What are the gaps in knowledge? What are the strengths of the Australian research community and how can these best be utilised to deliver new knowledge relevant to the Australian context.

So what does the future hold for suicide prevention?

Suicide is a wicked problem i.e. one characterised by complexity, interdependencies and multiple causes; constant change; no clear solution; requires behaviour change and commitment from the general public; and responsibility for sits across government, business and the community.

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

We must meet the challenges outlined above and change the way we work. That change is already on the agenda: SPA is leading its implementation through the National Coalition for Suicide Prevention which has been created within the principles and framework of Collective Impact.

Collective Impact is a structured and sophisticated approach much more valuable than the sum of the parts. It has shown great promise in US communities in addressing intractable social problems and members of the National Coalition firmly believe that it has potential to make a difference in suicide prevention. Collective Impact is an approach which can tackle the challenges of a wicked problem like suicide.

The most successful initiatives in the US have been those that engage all three sectors – community (like SPA), businesses and government (local, state and federal).

There are six elements which are integral to successful Collective Impact:
1. An agreed common agenda to which all participants will commit
2. Shared goals and measures
3. One common reporting framework

To complete the framework we must also have:
4. Mutually reinforcing activities
5. Continuous communication
6. One backbone organisation to drive the common agenda.

At its heart collective impact enables us to solve challenging social problems with the resources we already have at our disposal.

Setting the agenda for suicide prevention
We want to halve the number of suicides; we want to halve the number of attempts. That is the agenda: a 50% reduction in suicides in Australia over the next decade.

The formation of the National Coalition for Suicide Prevention includes more than 20 not-for-profit organisations including beyondblue, Lifeline, Black Dog Institute, RUOK? Day, SANE, National LGBTI Health Alliance and many others are all committed to making this change.

SPA is the backbone organisation driving the agenda, building continuous communication and managing stakeholder expectations.

We are under no illusion of the challenges we face but, with suicide statistics plateaued, the change in our approach cannot come quickly enough. Collective Impact is the way ahead and we call on all those working in suicide prevention to sign up to this ambitious agenda.

REFERENCES

When a suicide occurs, it is a traumatic event for a school or community and the impact on young people can be significant. Suicide can elicit a range of emotional and behavioural responses, according to headspace.

These will be unique for each individual and will depend on factors such as past experiences, level of support, personality type and how close a student was to the deceased person.

Talking to young people about suicide can feel daunting. Many people fear it will cause increased distress or even lead to the development of suicidal thoughts or suicide ‘contagion’ (see headspace fact sheet on Suicide Contagion).

It’s important to be thoughtful and sensitive when you talk to young people about suicide. The aim is to limit the harmful impact of the death and to promote positive coping strategies and good mental health. Below are some important factors to keep in mind.

1. **Give accurate information about why people suicide**
   Suicide is a complex behaviour caused by a range of factors and is rarely the result of a single event or problem. Many people who suicide had been experiencing mental health difficulties such as depression at the time of their death.
   This illness can make people feel hopeless and impact on their ability to think clearly and rationally. Providing information on the link between mental illness and suicide can encourage people to seek help for themselves or others, which will decrease the risk of suicide.

2. **Avoid blame**
   Young people often want answers about why a suicide has occurred, and this can lead to them blaming the death on a particular event or person. Explain that suicide is not simple and is often the result of a range of contributing factors. This can reduce the likelihood that blaming or scapegoating will occur.

3. **Don’t focus on the method of suicide**
   Avoid talking graphically or in detail about how the person died. Detailed descriptions of the death can be overwhelming and distressing, and can increase the risk of imitation by vulnerable young people. Keep the focus on how to manage the emotions brought up by the person’s death, and away from details of how someone has died.

4. **Address feelings such as anger and responsibility**
   Provide reassurance that a range of responses following a suicide are normal. Young people may feel angry towards the person who died or feel that they could have prevented the death in some way. Such feelings can lead to increased confusion and distress. Reassure them that they are not to blame and that feeling angry doesn’t mean they didn’t care about the person. Normalising these feelings and allowing young people to talk through their emotional responses can help in the grieving process.

5. **Encourage help-seeking**
   If a young person finds themself or a friend feeling overwhelmed, unable to cope or developing thoughts of suicide, encourage them to seek help. Let them know what their support options are. This will allow them to choose a
If you believe that a young person is at risk of suicide, you should seek professional support from your local mental health service or emergency department and keep the young person safe until help arrives. Remove any means of suicide available to them in the immediate vicinity, such as medications or weapons. Stay with him or her (or arrange for supervision) until they can be seen and assessed.

person they feel comfortable with and increase the likelihood that they will seek help. Options for support could be a parent or trusted adult, such as a teacher, school counsellor or family doctor.

6. Ask about suicidal thoughts

If you are worried that a young person might be at risk of suicide, it’s important to talk to them directly about your concerns in a calm and non-judgemental manner. It can feel uncomfortable asking someone directly about suicidal thoughts or plans, but it’s necessary in order to check whether a person is at risk and how imminent that risk is.

Asking questions directly can also be a huge relief for a young person struggling with thoughts of suicide. It gives them permission to speak openly about how they are feeling and the opportunity to gain support.

For more information on suicide or support and assistance visit headspace.org.au/schoolsupport or headspace.org.au

ACKNOWLEDGEMENTS


• South Australia Department of Education and Children’s Services, Catholic Education South Australia and Association of Independent Schools. (2010). Suicide Postvention Guidelines: a framework to assist staff in supporting their school communities in responding to suspected, attempted or completed suicide. South Australia: Government of South Australia, Department of Education and Children’s Services.

headspace, National Youth Mental Health Foundation Ltd is funded by the Australian Government Department of Health and Ageing under the Youth Mental Health Initiative Program.

Suicidal thoughts can be pretty scary; however it’s important to understand them for what they are. Thoughts and feelings are quite different to actions, so even though you’re experiencing suicidal thoughts you don’t have to take action. If you’re feeling suicidal there are things you can do to keep yourself safe.

This might help if you ...

• Think about suicide sometimes
• Feel overwhelmed and don’t know what to do
• Want to challenge suicidal thought

Thoughts and feelings

If you’re at a point where sometimes you think about killing yourself, or like you want to die, you may be feeling as though you cannot solve the difficulties you are experiencing. Sometimes life can be really overwhelming and it can be incredibly difficult to know how to handle things.

If you are beginning to feel like there’s no way out, it might help to know that many people who think about killing themselves find that soon after those feelings pass.

Maybe you feel as though there is no one you can trust to help you – or that you just don’t belong with the people around you. Sometimes it is difficult to reach out to others for support, yet the contact with others can make a real difference.

If you think that you need to talk to someone about how you’re feeling and there’s no one around that you trust, have a look at the ‘Emergency help’ page on the website for some services that can offer support.

Understanding suicidal thoughts

It’s important to remember that suicidal thoughts are only thoughts. Just because you’re thinking about killing yourself, doesn’t mean you have to act on these thoughts. Suicidal thoughts don’t last forever, and often they pass quite quickly.

It’s totally normal to feel overwhelmed and stressed if you’re going through a tough time and sometimes it can feel like nothing will get better. If you are thinking of killing yourself because you can’t think of any other way out, it’s important to know there are a number of ways you can keep yourself safe and work through your feelings.

Things you can do to challenge these thoughts

• Seek help early – Talk to someone about how you’re feeling; a family member, friend, local doctor or support service can be a good place to start. If you feel like people aren’t listening, keep asking for help until someone does.
• Postpone any decision to end your life – By postponing your decision for 24 hours you might find that the desire to end your life passes. You can also find the support you need to talk through how you’re feeling if you give yourself time.
• Avoid being alone (especially at night) – You don’t have to go through this alone. Stay with a family member or friend, or have someone stay with you until the thoughts of suicide decrease. If someone can’t be there, chat to a service online or use one of the 24-hour crisis services.
• Have a plan of action – Ask someone you trust if they would mind being your go-to person if you’re feeling overwhelmed or upset.
• Avoid drugs and alcohol – Many drugs can make you feel even worse. They won’t solve your problems and may even make you do things you wouldn’t normally do.
• Set yourself small goals – Try to set goals that will make you feel in control and help you move forward. Write them down and tick them off when you’ve achieved them.
• Write down how you’re feeling – Sometimes writing a journal, story, song lyrics or poem can help to understand yourself better and think about alternative solutions.
• Talk to someone who can help – Contact a crisis service – they can help with the immediate situation, and help you find others for longer term support. You can also make an appointment with your doctor or local health professional. Find someone who knows about treatments and strategies to help you get through your tough time.

Inspire Foundation (last reviewed 16 February 2014).

Sometimes I want to die (Fact sheet).
SUICIDE PREVENTION – KNOWING THE SIGNS

This youthbeyondblue fact sheet encourages young people to identify suicide warning signs and know when to get help

It is not always possible to know if someone is thinking about suicide; people don’t often talk directly about it, sometimes their communication is indirect and even unclear. If you or someone you know is thinking about suicide keeping safe is the first priority. From there it is about finding the support you need to refocus your thoughts, develop other options and rebuild hope.

**Why does suicide happen?**

Suicide is a complex issue and is a relatively rare event in young people, however when it does happen it has tragic consequences and sets off deep ripple effects for individuals, families and the whole community.

There are a broad range of reasons that might contribute to a young person considering suicide. It’s related to their mood, what has happened in the past, what is happening currently in their lives, how they are coping and how supported and connected they feel.

Young people who think about taking their life often believe that nobody cares about them, that they don’t belong and that things are hopeless. They are often exhausted by their distress and unable to think clearly through any other options. They might be so unhappy that they are unable to sleep, eat, or enjoy any part of their life.

People with conditions such as depression, bipolar disorder, eating disorders and substance abuse are more likely to think about suicide.

**Warning signs**

Sometimes there are things that people say or do that can help you begin to understand how they are feeling. It might be the words they use (“No one cares about me anymore.”), a change in how they act around you, or perhaps a dramatic change in their mood. Young people might display one or more of these behaviours at times of stress. If you see these signs then it is important to ask about what is going on, how they feel and whether they are thinking about suicide.

Other warning signs for suicide include:

**How they might feel**

- Sad, angry, ashamed, rejected, desperate, lonely, irritable, overly happy or exhausted.
- Trapped and helpless: “I can’t see any way out of this.”
- Worthless or hopeless: “I’m on my own – no one cares. No one would even notice I was gone.”
- Guilty: “It’s my fault, I’m to blame.”

**What they might be doing**

- Spending less time with family and friends.
- Isolating themselves, pushing people away.
- Talking or writing about death, dying or suicide and giving away possessions.
- Stopping doing things that they previously enjoyed.
- Increasing alcohol and/or drug use.
- Doing dangerous, life-threatening actions without concern for their safety.
- Changing their approach to their physical health; changes in sleep, diet, level of exercise.

**What else they might say**

- “They’d be better off without me.”
- “I just don’t fit in anywhere.”
- “What is the point? Things are never going to get any better.”
- “I just can’t take this anymore.”
- “Nothing I do makes a bit of difference, no one can help me.”
- “If I died no one would miss me.”

**If you are suicidal**

Many young people think about suicide but for most young people that is as far as it gets; they do not go on to act on their thoughts and take their own life.

- Having suicidal thoughts can be scary. You may have never had them before, or perhaps the thoughts have been there for a while and you are not sure what to do. You may be ashamed to talk about it or worry that people will not take you seriously and just tell you to “Get over it”.

In the short term you need to find ways to stay safe. Once you are safe
you can work out how you are going to get the help you need.

**Let someone know**
- Share how you feel with someone you trust and feel comfortable with, a family member, teacher, doctor or other health professional.
- Try and think about it as any other conversation. You can describe what has happened, how you feel and what help you need. It’s best to be direct so that they understand how you feel.
- Be prepared for their reaction. Often people who learn that someone is suicidal can be quite confused and emotional at first. Just keep talking and together you can find a way through it.
- Ask your friends/family member to help you find support; in person, online, over the phone.
- Understand that others do care. It is important to have support from your friends but if you tell them about your suicidal thoughts you cannot expect them to keep it a secret. They want to be able to help you stay safe and that usually means calling in extra help.

**Stay safe**
- Remember that thoughts of suicide are just thoughts; you do not have to act on them. These thoughts might only last a few minutes; you might feel differently in a few hours.
- Postpone any decisions to end your life. Give yourself time to get the support you need.
- Remove anything in the house that you might use to impulsively harm yourself – maybe give it to a friend.
- Keep crisis line phone numbers or web links in your mobile phone for easy use.
- Avoid being alone. Have someone near you until your thoughts of suicide decrease.
- Avoid drugs and alcohol. They can intensify how you feel and make decision making harder.

**Decrease stress**
- Cut back on commitments, postpone major decisions until you are more able to make them, ask to take on different responsibilities at home or at work, or take time out to do activities you enjoy.

**Find what works for you**
- Set yourself some tasks to do on a day to day basis, or even hour by hour if you need to. Reward yourself as you achieve small goals.
- Learn about different coping strategies, including mindfulness. [smilingmind.com.au](http://smilingmind.com.au) helps you to practise mindfulness; a useful tool to manage suicidal thoughts.
- Do some physical exercise every day, preferably outdoors, no matter how hard it is to get going. Not only will this help to give a natural boost, it should help you to sleep better at night.
- Consider asking a friend to ‘buddy’ with you for regular exercise sessions.
- Notice the times that you feel a bit better. These times might be short at first, 5-10 minutes, but as you learn to cope in different ways these times should become more frequent and last longer.
- Do things regularly that you enjoy. Catch up with friends, neighbours and family members, or perhaps join a group doing something that interests you.
- Try to challenge how you think about things. By thinking in more realistic, positive and reassuring ways you can influence how you feel. It’s about changing your unhelpful thoughts to thoughts that can help you to move forward and feel more in control.

**Make a safety plan**
- Make a list of things that you can do when you notice your suicidal thoughts returning. Include things that calm you down, things you enjoy, e.g. talking with friends and things that help you to refocus your thoughts. For other ideas see suicidecallbackservice.org.au/are-you-thinking-about-suicide-or-self-harm/making-a-safetyplan
- Think about who you can contact ( beyondblue, Kids Helpline, headspace, ReachOut, Lifeline, Suicide Callback Service).

**Helpful thinking:**
- Is this situation as bad as I am making it out to be?
- “I don’t think that went very well, but I guess I could try again.”
- “I wish that hadn’t happened, but it has, so I just have to accept it.”
- Is there something I can learn from this situation, to help me do it better next time?

**Unhelpful thinking:**
- “What is the point? Things are never going to get any better.”
- “Nothing I do makes a bit of difference, no one can help me.”
- “That was a disaster. Nothing ever works out for me.”
- “It’s never going to work.”

- Get support from a health professional in person, online or over the phone. A health professional can help you work out how you are feeling and offer ideas about ways to approach the problem. They can offer a different perspective and help you to achieve your goals. For more information on what service to contact, see Where to find support on the website.

**For a friend**
It can be hard to understand why someone wants to take their own life but whatever your reaction, it is important to talk with them about it. It can be a challenging, unfamiliar and uncomfortable conversation to start but it might be lifesaving. This website offers...
some practical suggestions on having a conversation about suicide: conversationsmatter.com.au

Most people who feel suicidal recover from these intense feelings but it’s often difficult to know what to say or how to make sure the person is safe. As a friend you can support them and let them know that there is help available; they are not alone. Support from other friends, family and health professionals is also essential at these times.

**Seek help**
- Encourage them to talk with someone who can help – their parents, teachers, doctor or a local counsellor. Another great option is beyondblue, Kids Helpline or Lifeline.
- Family, friends and health professionals can make a big difference in helping people stay safe and find positive reasons for living. See below for health service contact details.

**Listen**
- Make time to listen. Sometimes listening is what the person really needs as it helps to ‘let it out’.
- Let them know you are there if they need to talk.

**Talk**
- Ask them directly about suicide. “You’ve been really down lately and you haven’t been going out for weeks, I’m wondering how you are feeling? I’m wondering if they might be so bad that you are thinking about killing yourself and if you have made any plans?”
- Talking about suicide gives young people a chance to share how they feel and explore what they might need to feel better.
- If you think you said the wrong thing, try again. Let them know you care, that you found it hard to hear, but that you want to help them. You don’t need to have a the answers but you can help them to stay safe while they get other support.

**Speak up**
- If your friend is joking or talking about suicide, giving possessions away, or saying goodbye then you need to take it seriously. You might te their parents, partner or trusted adult, or contact emergency services for help.
- Even if you promised not to tell, what’s most important is that your friend needs your help to stay safe. You can talk with them another time about why others had to get involved. Suicide is not an easy situation to cope with. It’s not your sole responsibility to take care of your friend. It’s OK to ask for the support of others.

**Take care of yourself**
- Supporting someone who is suicidal can be confronting and emotionally exhausting.
- Try to find the balance between supporting them and looking after yourself.
- Be clear about your boundaries – telling them they can call you ‘any time’ might mean that you miss out on much needed sleep. Know what your limits and boundaries are. If you run yourself into the ground you won’t have anything to offer your friend.
- Look after your physical health: eat well, exercise daily and get regular sleep.
- Look after your emotional health too; talk with someone about what is happening. You can respect your friend’s privacy but still talk to someone about how it is affecting you and what you should do to help your friend.
- Online and phone support services can also help you in these situations.

Many young people think about suicide when things seem impossible or like there is no way out. Most young people find a way to shift their thoughts from this sense of hopelessness and despair to thoughts about their future. They make small changes each day to how they think, who they spend time with and what they do. It is about refocusing their thoughts on what they can change, and moving on from the things that they cannot.

**WHERE TO FIND SUPPORT**

For help with how you’re feeling

**beyondblue**
www.youthbeyondblue.com
Learn more about anxiety and depression and how to talk about it with your friends, or talk it through with our Support Service. Ph: 1300 22 4636
Email or chat to us online at www.beyondblue.org.au/getsupport

**Kids Helpline**
www.kidshelp.com.au
Ph: 1800 55 1800

**headspace**
www.headspace.org.au
www.eheadspace.org.au
Ph: 1800 650 890

**ReachOut**
Reachout.com

**Lifeline**
www.lifeline.org.au
Ph: 13 11 14

**Suicide Call Back Service**
www.suicidecallbackservice.org.au
Ph: 1300 659 467

TALKING ABOUT SUICIDE

SUICIDE CALL BACK SERVICE OFFERS SOME IMPORTANT ADVICE FOR PEOPLE WHO NEED TO DISCUSS THEIR SUICIDAL FEELINGS

Talking to someone about your suicidal feelings can be very difficult. You may be worried that you will be told to stop overreacting or that such thoughts are a sign of weakness. You might feel embarrassed or ashamed.

You might feel that it is easier to keep it to yourself rather than taking the risk of telling someone. However, if you choose the right person, then talking with them about how you are feeling will usually help.

IN AN EMERGENCY

If you are in immediate danger, or concerned for your safety in any way:

• Call 000 (or 112 from a mobile) and request an ambulance. Stay on the line, speak clearly, and be ready to answer the operator’s questions
• Visit your local hospital’s emergency department
• Call your local Public Emergency Mental Health Service.

Each of these emergency services teams are specially trained to support people in crisis, including people feeling suicidal, and are able to keep you safe.

WHO CAN I TALK TO?

Someone you trust

It is important to choose someone who you can trust and who you can be honest with. It can be a friend or family member, a doctor, counsellor or someone else in your life who you feel comfortable with.

You can also talk to a counsellor on a helpline such as the Suicide Call Back Service, which is free and available 24 hours a day, seven days a week.

What do I say?

Be clear and honest with them about all of the things that are troubling you, including your suicidal thoughts and feelings. Begin by talking to someone about what’s stressing or upsetting you, let them know how you’ve been struggling and how you’re feeling.

Listed below are some ideas to get you started and you can adapt these or use your own words. This is a difficult conversation to start so take your time so you are comfortable and ready.

• “I have been having a difficult time lately, I am wondering if we can talk about it.”
• “I am feeling really upset and worried about my thoughts at the moment.”
• “Things have felt a bit out of control recently and I am feeling really upset, I need to talk about it.”

Talking to a professional about suicide

When talking about your thoughts about wanting to end your life or hurt yourself to a health professional, it is important to let them know whether you have:

• Been thinking more often or in more detail about how you would end your life or hurt yourself
• Access to the means to carry out these ideas, or taken steps to obtain these means
• Thought about when and how you would end your
Be clear and honest about all of the things that are troubling you, including your suicidal thoughts and feelings. Begin by talking to someone about what’s stressing or upsetting you, let them know how you’ve been struggling and how you’re feeling.

Talking about suicide is hard, but it is important to get support for yourself at this difficult time.

For more information see Accessing professional support and Helping yourself when you are suicidal at http://suicidecallbackservice.org.au

Having a friend who is feeling suicidal can be a pretty confronting thing to deal with. If you think they are in immediate danger, there are services you can call. Sometimes it can be tough if your friend needs your help, but there are always things you can do to help. Make sure you look after yourself first and if you feel like it’s more than you can handle, talk to someone who can help.

Sometimes it can be tough if your friend needs your help, but there are always things you can do to help. Make sure you look after yourself first and if you feel like it’s more than you can handle, talk to someone who can help.

**THIS MIGHT HELP IF ...**
- You’re worried about your friend
- You think your friend is suicidal
- You’re not sure what to do.

**WHAT YOU CAN DO RIGHT NOW**
If you need help now please call Kids Helpline 1800 55 1800 or Lifeline on 13 11 14. If your friend is in immediate danger please call 000. For more information read the ‘Emergency help’ section on ReachOut.com

**HOW CAN I BE SURE THEY NEED MY HELP?**
If your friend tells you they are feeling suicidal or that they want to end their life, it’s important to take it seriously. It’s totally understandable that hearing your friend say this might make you feel overwhelmed or worried, especially if your friend is very upset or angry. However, if someone talks about wanting to die by suicide, the positive thing is that they are not keeping it to themselves; by telling someone they are most likely reaching out to you for help.

**THINGS YOU CAN DO**

*Don’t keep it a secret*
Your friend may have asked you to keep it a secret or made you promise not to tell anyone. They might be frightened of what might happen if someone else knows. It is very important that you do tell someone – even if you have promised you would keep it a secret. Your friend might get mad at you – but it’s better that they are alive and well.

The situation puts a lot of pressure on you – so the
best thing to do is to talk to a parent, counsellor, teacher, or doctor.

Encourage your friend to seek help

It's important your friend seeks help from a parent, counsellor, psychologist, youth worker, teacher or doctor, or one of the helplines mentioned on the previous page. Although it might seem hard, these people have training to help your friend move to a better, happier place.

If your friend refuses to see someone

Keep encouraging them to see someone. If you feel able to, you might offer to go with your friend when they speak to someone about their suicidal thoughts. It might also be helpful to forward them the fact sheets and stories on ReachOut.com about suicidal thoughts.

Offer your support

It's probably really scary for your friend when they realise they need help. Let your friend know that you care and spend time with them. Just knowing that somebody cares about them can be reassuring because they may feel very alone and as if no one cares.

Choosing when to talk

Timing can be an important part of talking to someone about sensitive stuff. If possible, and if they are not at immediate risk of harming themselves, try to choose a time when you're both relaxed. If you're not sure what to say, you might try saying 'I'm worried about you', 'You told me the other day you felt like ending your life, do you still feel that way?'.

Ask them to postpone the decision/create a toolkit

While your friend may feel like they have to act now, it's worth encouraging them to postpone that decision. They can keep a list of other things they can do to distract themselves and might find that their suicidal thoughts go away over time.

It's probably really scary for your friend when they realise they need help. Let your friend know that you care and spend time with them. Just knowing that somebody cares about them can be reassuring because they may feel very alone and as if no one cares.

Thoughts don't need to lead to action

Remind your friend that thoughts about taking their life are just thoughts and it doesn't mean they have to act on them.

Get informed

It might be helpful to have a general knowledge of suicide and depression. By doing this you may be able to better understand what your friend is going through and what might help. You can do that on ReachOut.com

Looking after yourself

When you are worried about a friend you might feel stressed or overwhelmed and forget to look after yourself. Speak to someone you trust, such as a family member, friend or counsellor and make sure you spend some time doing what you enjoy. You may want to play sport, hang out with other friends, listen to music, or go for a walk.

FINALLY

It's also important to remember that even though you can offer support, you are not responsible for the actions or behaviour of your friend. If they are not willing to help themselves it is not your fault. Wanting to help your friend is understandable and really kind, but their actions are their own and you can't control what they decide to do.

What can I do now?

- Organise to do something that they like to do, like going for a walk or watching a movie.
- Talk to someone who can help like a teacher, parent or doctor.
- Encourage them to call a helpline if they are in distress.
Supporting someone after a suicide attempt

Often people find it difficult to support someone who has attempted suicide because they feel they don’t know what to say. This advice from SuicideLine may help.

Common reactions after someone attempts suicide

Discovering that someone you care about has tried to end their life can be a devastating experience. You may initially experience emotions such as shock and denial. Sometimes those close to the suicidal person blame themselves for what has happened, thinking, for example, “if only I’d watched them more closely”. The fact that someone close to you or a loved one has attempted suicide is not your fault.

Other common feelings and reactions to the suicide attempt of a loved one include:
• Anger: How could they do this to us?
• Shame: I have to keep this secret.
• Guilt: Didn’t I love/watch/listen to them enough?
• Fear: Will they try again?
• Avoidance: If we pretend this didn’t happen, it will go away.
• Minimisation: They are just trying to get attention.
• Cutting off: This is not my problem – someone else can deal with it.

Unhelpful reactions to a suicide attempt

It is important for you to be aware of your own feelings, and avoid reacting in ways that could block communication or cause your loved one to react angrily or withdraw. Unhelpful responses include:
• Panicking: “This can’t be happening. I don’t know what to do – what do we do?”
• Name-calling: “You’re a real psycho.”
• Criticising: “That was such a stupid thing to do.”
• Preaching or lecturing: “You know you shouldn’t have done that; you should’ve asked for help.”
• Ignoring: “If I just pretend this didn’t happen, it’ll go away.”
• Abandoning the person: “I can’t take this, I have to leave.”
• Punishing the person: “I’m not talking to them until they straighten themselves out.”
• Dramatising: “This is the worst possible thing you could have done!”
• Simplifying things or using a ‘quick-fix’ approach: “You just need some medication, and then you’ll feel yourself again.”
• Being angry or offended: “I can’t believe you’d try that!”
• Making the person feel guilty or selfish: “How did you think this would make me feel?”

What to say to someone who has attempted suicide

Often people report that they find it difficult to
support someone who has attempted suicide because they feel they don’t know what to say. It can be hard to find the right words when you’re feeling overwhelmed and emotional yourself. Create a ‘safe space,’ where the person feels loved, cared about, accepted, supported and understood. Letting the person know you support them, and asking open-ended questions, can help to open the lines of communication.

The following suggestions may serve as prompts:

- I’m sorry you’ve been feeling so awful. I’m so glad you’re still here.
- I’m here for you. Remember that you can always talk to me if you need to.
- I want to help you. Tell me what I can do to support you.

Consider assisting the person to write a safety plan that will detail the steps they need to take to keep themselves safe if they feel suicidal. Having a concrete plan in place may help both of you feel more prepared and in control.

**How to support someone who has attempted suicide**

- Be available and let the person know you will listen. It is vital to create a ‘safe space’ for the person to talk – this helps to build or re-establish trust between you and the person you are concerned about.
- Try to understand the feelings and perspective of the person before exploring solutions together.
- It may be advisable to remove possible means to suicide, including drugs and alcohol, to keep the person safe.
- Support the person in exploring and developing realistic plans and solutions to deal with their emotional pain. In order to let go of suicide as a solution, they will need to see real changes in their life. It is usually a case of making small steps in the beginning, as the person’s difficulties haven’t been created overnight.
- It is important for the suicidal person to assume as much responsibility as possible for their own welfare as they are capable of at that time. This might be difficult for you to consider, as you might not feel able to trust your loved one at the moment.
- Enlist the help of others and make sure you get family and friends to assist you to support the person.
- Remember that you do not have to fill the role of counsellor, psychiatrist or doctor yourself. Encourage your loved one to utilise the professional supports available to them.
- Consider assisting the person to write a safety plan that will detail the steps they need to take to keep themselves safe if they feel suicidal. Having a concrete plan in place may help both of you feel more prepared and in control about the possibility of future suicidal thoughts.

**Telling other people about the suicide attempt**

Unfortunately, there is still a degree of stigma surrounding suicide. This may make it difficult to talk about your loved one’s suicide attempt, as you may fear that you or they will be judged or criticised.

It is important to remember that it is up to you who you choose to tell about the situation, and how much you reveal to them. You may find it helpful to prepare something to say when asked about the suicide attempt, such as a simple: “yes, it’s a difficult time for us, but we’re getting him/her the support he/she needs.” Speaking to people who have also been in similar situations, such as through a carers’ support group, may offer you a source of non-judgemental support and understanding.

**Looking after yourself**

Supporting someone who has attempted suicide can be emotionally draining, stressful and exhausting. It is impossible to watch over someone 24/7. It is vital that you look after yourself and get the support you need. This is not something you need to deal with alone. Ensure you have adequate support systems in place yourself. Identify trusted family members or friends that you can talk to, or join a local support group (visit JIGSAW, http://jigsaw.onteline.org.au, our community services database to search for groups in your area). If you are finding it difficult to deal with the strain of the situation, you may also wish to consider counselling or other professional support for yourself.

**SuicideLine**

SuicideLine provides free professional, anonymous support 24 hours a day seven days a week across Victoria. The counsellors of SuicideLine provide specialist telephone counselling and information to anyone affected by suicide. If you are thinking about suicide, worried about someone, or have lost someone to suicide, you can call us on 1300 651 251.

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*Supporting someone after a suicide attempt (Tip sheet).*  
AFTER A SUICIDE ATTEMPT

NOW MORE THAN EVER, IT IS IMPORTANT TO LOOK AFTER YOURSELF, ACCORDING TO THIS ADVICE FROM SUICIDE CALL BACK SERVICE

If you have attempted suicide, you may have mixed feelings about what you have been through. It may be that you feel embarrassed, confused, relieved, disappointed, or resentful that you need help. It may compound your sense of failure.

A common experience for people after a suicide attempt is fatigue and physical exhaustion. The suicide attempt, reactions from other people and treatment in the emergency department may all be overwhelming for you right now. It is important to remember that while all these feelings are probably very intense at the moment, they will pass and a return to the normal pattern of living is possible.

REASONS TO LIVE

It might be helpful at this time to reflect on your reasons to live. It may be your family, children, friends or even a beloved pet that are your most important reasons for living. Perhaps it’s a passion or interest that is meaningful to you. While reflecting, you may want to write them down and keep these thoughts accessible in case you are feeling suicidal in the future.

BUILDING SUPPORT

Despite the many prevention programs, suicide is still a sensitive subject and is largely misunderstood. The stigma surrounding suicide might cause you to worry about what other people are thinking. Remember that it is up to you who you choose to talk with about what is going on right now. At this time, it is important to be kind to yourself and surround yourself with trusted and supportive people.

Building a strong support network is a key step in recovering from a suicide attempt and keeping safe in the future. It is helpful to have at least one person you can confide in, especially if you start to have thoughts of ending your life again.

Following a suicide attempt, it is likely that you have been referred to a psychiatrist, psychologist or other mental health professional. It is important to call on this support to help you get through this tough time, and deal with the issues that brought you to this point.

COPING WITH SUICIDAL THOUGHTS

Recovery from suicidal feelings is possible. You can learn how to manage these thoughts in the future to keep yourself safe, or you may get to a place where you no longer have these thoughts at all. Other people have recovered from suicide attempts and you can too. Remember that even if you feel like you are alone, there are people who can help you.

Here are some ideas that can be put in place now to keep you safe in the future:

CREATE A SAFETY PLAN

Working with your counsellor or doctor, create a plan that you can follow should the suicidal thoughts return. When creating a safety plan, it is important to be as honest as you can to ensure you are comfortable with your plan and it meets your needs. To get some tips on creating a safety plan see Making a safety plan on the following page.

KNOW WHERE TO GET HELP

As part of your safety plan, create a list of services that you can turn to when you are in trouble. Helplines can be a good place to start. The Suicide Call Back Service (1300 659 467) provides help to people who are at risk of suicide 24 hours a day, 7 days a week. It is a good idea to have your safety plan with you when you make the call because the counsellor can work with your plan to help keep you safe. If you don’t have a plan, a counsellor can help you create one.

LEARN THE THOUGHT TRIGGERS

Identify what sets off the negative thoughts. It may be that these thoughts are triggered when you spend a lot of time alone, when you are exposed to stressful situations, or perhaps on the anniversary of a painful event. Whatever the trigger is, make use of the safety plan when your triggers arise before you start to have the suicidal thoughts.
Learn some relaxation techniques

This can be a breathing exercise, progressive muscle relaxation or meditation. These activities can help to calm you and distract you from the intense thoughts. For some examples of relaxation techniques see the tip sheet, Helping yourself when you are suicidal on www.suicidecallbackservice.org.au.

Distractions and stress relievers

Write down some activities that you may find helpful in distracting you from the intrusive negative thoughts.

These might include the following:
• Listening to uplifting music
• Reading a book
• Drawing, sketching or painting
• Going for a walk
• Take time out to treat yourself to a small thing you ordinarily enjoy, and savour it.

Taking care of yourself after a suicide attempt

Now more than ever it is important to look after yourself. For a while at least, life might feel dreary, uncomfortable or strange. Establishing a routine can help you to get through this difficult period. Eating well, getting enough sleep and doing some physical activity will help improve your mood. You can start introducing more things into your routine once you feel ready.

Should you continue to have suicidal thoughts, it is important that you get help. If you're already receiving professional help or support, it’s important that you stay in touch with these services, particularly if you’re feeling distressed. If you feel you need some extra support, you may wish to consider calling a crisis line like the Suicide Call Back Service (1300 659 467) or Lifeline (13 11 13).

You could also reach out to a trusted friend or family member. It’s very important that you are honest with the person who is helping you. Let them know how you’re feeling, and what you think you need to ensure you get the best possible help.

Recovery is different for everyone and it may take time, but it is possible.

On the Line Australia Inc.

How to make a safety plan

Suicide Call Back Service explains how to make a suicide safety plan

Work together with someone you trust – such as a close friend, family member, your doctor or counsellor to develop your suicide safety plan. It is a good idea to get these people involved, since you may need to call on them and it is important that they know the best way to care for you.

It is best to create the plan at a time when you are feeling well and thinking clearly, rather than waiting until you are feeling overwhelmed and suicidal. Put your suicide safety plan in writing and keep it in a place where you can easily find it. Information to include in your safety plan:

1. When the plan should be used. Familiarise yourself with what types of situations, thoughts and feelings might lead to suicidal urges for you. List the warning signs so that you can refer to them when you are deciding on whether to activate your plan.

2. What you can do to calm/comfort yourself when you are feeling suicidal. List the activities that you know soothe and comfort you when you are upset.

3. Create a list for yourself of all your reasons for living. When you are feeling suicidal, it is easy to get caught up in the pain you are feeling and forget the positives in your life. Your list may help you to refocus your attention until the suicidal feelings pass.

4. Who you can talk to. List names and contact details and include back-ups in case your first choice is unavailable.

5. Who you can talk to if you need professional assistance. Create a list of professional resources available to you, along with their contact details and availability.

6. How you can make your environment safe. This may involve removing or securing any items that you are likely to use to hurt yourself and not doing things that you know make your feelings stronger or longer lasting.

7. What you can do if you are still not feeling safe. Keep the name and address of your nearest hospital emergency department or telephone crisis line.

8. Make a safety plan commitment. The last step is to make a commitment to your safety plan. This means committing to yourself that you will follow this plan when the need arises, and then committing aloud to someone else (e.g. your counsellor, a trusted friend) that you will follow this plan. This is also called “a safety contract.”

The death of someone you care for is always a painful event, but the grief felt by family members and friends can be more complex when the cause of death is suicide.

Around 2,000 Australians die from suicide every year. Some estimates suggest that around one in four people knew someone who took their own life.

Even though suicide is, unfortunately, something many people are touched by, the social taboo surrounding this issue often means that family and friends may feel stigmatised and isolated.

**Common responses to suicide**

Common responses to the suicide of a family member or friend include:
- Remorse over lost opportunities
- Anger at the person who took their own life
- Guilt over failed responsibilities, real or imagined
- Isolation caused by a sense of self-imposed shame
- Loneliness when others keep their distance
- Anger toward those perceived to have contributed to the suicide
- Awkwardness when others don’t know how to respond
- Shock associated with facing the traumatic and sometimes unexpected nature of death
- Difficulty accepting that the death was by suicide
- Fear that powerful grief reactions may not be normal
- Difficulty making sense of the suicide.

**The question ‘why’**

Family and friends often grapple with the question of why the person chose to end their own life. In many cases, the question is complicated and remains open-ended.

Suicide may be associated with:
- Mental illness, such as depression, bipolar disorder or schizophrenia
- Chronic pain
- Physical disability
- Stress of certain life events.

**Grief after a suicide**

Family and friends often say that the bereavement felt after a suicide is different to that felt after other bereavements. In addition to the powerful feelings of grief, people also grapple with anger, relief and guilt.

Different people grieve in different ways. Family members need to give each other space and understanding so that everyone can grieve in their individual ways.

Some of the initial feelings of grief may include:
- Shock or numbness
- Strong feelings of anger or confusion
- Emotional withdrawal from others
- Feelings of depression and loneliness
- Difficulties with everyday routines, such as eating and sleeping
- Guilt.

In time:
- The strong feelings start to reduce.
- The loss isn’t always uppermost in the person’s mind.
- The person can start finding meaning and purpose in their life.

**Guilt is a common feeling after a suicide**

It is common to feel guilty: that you ‘could have done more’. People may feel they should have picked up the warning signs, or blame themselves for things they did or didn’t do in the period leading up to the suicide. Many feel anger and betrayal. These are common and normal reactions.
Feelings of relief

Some people who end their own lives were affected by mental illness, such as depression, bipolar disorder, schizophrenia or other conditions. Family and friends who witnessed the distress caused by mental illness (especially when untreated) may feel a sense of relief that the person's torment is over. This is a normal reaction and people should not feel guilty about it.

Negative reactions

Family and friends may come across people who have negative reactions towards them. For example, some may see suicide as a mark of failure. Others may not know how to respond because suicide is seen as a socially unacceptable cause of death. Some people simply avoid the issue out of embarrassment.

The guilt, pain and confusion felt by many family members and friends can be compounded by these attitudes, and they may mistakenly feel that the person ended their life instead of simply 'facing their problems'.

The social taboo surrounding this issue often means that family and friends may feel stigmatised and isolated.

Suggestions for family and friends

Suggestions to help you cope with the suicide of someone you care for include:

• Give yourself time to come to terms with your loss.
• Try not to deny your feelings.
• Remember that grief is a normal reaction, even when your feelings seem too intense to be normal.
• Work through your feelings, alone and with others.
• Support other family members.
• Be vigilant about signs of depression or suicidal thoughts in yourself and other family members and seek help from a doctor if these occur.
• Be honest with children and explain the suicide in language appropriate to their age.
• If friends seem awkward or don't know what to say, tell them what you need.
• Accept that some friends won't be able to give you the kind of emotional support you need. Consider joining a support group in your area.
• Anticipate that important events, such as birthdays and Christmas, will provoke strong feelings.
• Seek professional bereavement counselling.

If at any time you are worried about your mental health or the mental health of a loved one, call Lifeline 13 11 14.

Where to get help

• SANE Australia Tel. 1800 18 SANE (7263)
• Need Help? Chat live with a SANE Helpline Advisor (Available Monday–Friday, 9am–5pm AEST).
• Your doctor
WORKSHEETS AND ACTIVITIES

The Exploring Issues section comprises a range of ready-to-use worksheets featuring activities which relate to facts and views raised in this book.

The exercises presented in these worksheets are suitable for use by students at middle secondary school level and beyond. Some of the activities may be explored either individually or as a group.

As the information in this book is compiled from a number of different sources, readers are prompted to consider the origin of the text and to critically evaluate the questions presented.

Is the information cited from a primary or secondary source? Are you being presented with facts or opinions?

Is there any evidence of a particular bias or agenda? What are your own views after having explored the issues?

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MULTIPLE CHOICE 55-56
Brainstorm, individually or as a group, to find out what you know about suicide awareness and prevention.

1. **What is suicide, and who does it affect?**

2. **What is the difference between a risk factor and a warning sign in relation to suicide?**

3. **What is attempted suicide, and why should it be taken seriously?**

4. **What is the meaning of the term ‘suicide contagion’?**
“Suicide is rarely the result of a single event or factor but can be understood as a complex interplay of biological, psychological and environmental factors that leave a person feeling desperate and hopeless about life.”

Make a list of five possible risk factors or warning signs which may be associated with suicidal behaviour. Identify your answers as either a risk factor or warning sign and include how best to respond to these.

1. ____________________________

2. ____________________________

3. ____________________________

4. ____________________________

5. ____________________________
Complete the following activity on a separate sheet of paper if more space is required.

Everyone has a role to play in preventing suicide. Form into pairs or small groups, to discuss what you could do if you were concerned that someone close to you is thinking about suicide.

Consider how you would respond to that person’s situation, what action you would take to help him or her, and mention the potential avenues of support that may be available. In your response also discuss the types of information you would include in developing a safety plan with that person.
Complete the following multiple choice questionnaire by circling or matching your preferred responses. The answers are at the end of the next page.

1. Which of the following groups have been identified as being at a higher risk of suicide? (select all that apply)
   a. People experiencing mental illness
   b. Women living in urban or city areas
   c. People who identify as lesbian, gay, bisexual, transgender or intersex (LGBTI)
   d. Elite athletes
   e. Children under the age of 12
   f. Aboriginal and Torres Strait Islander peoples
   g. Men living in remote or rural areas
   h. People experiencing chronic pain or illness
   i. Armed forces veterans

2. Which of the following is considered a potential trigger to suicidal behaviour? (select all that apply)
   a. Losing a job
   b. Travelling
   c. Suicide of a close friend
   d. An unexpected change in life circumstances
   e. Relationship breakdown
   f. Missing the bus
   g. Death of a loved one
   h. Being abused or bullied
   i. Experiencing a debilitating accident
   j. Watching television
   k. Financial stress

3. Which of the following are unhelpful reactions to a suicide attempt? (select all that apply)
   a. Being angry
   b. Listening
   c. Lecturing
   d. Abandoning the person
   e. Panicking
   f. Offering support
   g. Dramatising
   h. Telling someone else
   i. Criticising

4. What does the term ‘suicidal ideation’ mean?
   a. When one suicide or suicidal act increases the likelihood that others will attempt or complete suicide.
   b. Actions or initiatives to reduce the risk of suicide among populations.
   c. Non-fatal self-injury with the intention of causing death.
   d. When an individual deliberately hurts or mutilates their body without the intent of suicide.
   e. Thoughts about attempting or completing suicide.
   f. The term given to activities and programs that are intended to assist those who have been bereaved by suicide to cope with what has happened.
5. There are a lot of myths and misconceptions about suicide. Respond to the following statements by circling either ‘True’ or ‘False’:

a. People who talk about killing themselves never do it. __ True / False

b. If someone tells you they have thoughts of suicide you are bound by confidentiality and can’t tell anyone. __ True / False

c. In Australia, the highest risk of suicide occurs in men in their 30s and 40s. __ True / False

d. If someone wants to end their life, there’s nothing you can do to stop them. __ True / False

e. Undiagnosed or untreated mental illnesses are the most common risk factor for suicide. __ True / False

f. Aboriginal and Torres Strait Islander people are twice as likely as non-Indigenous people to take their own lives. __ True / False

g. Men are four times more likely to die by suicide than women. __ True / False

h. More people die from road deaths than from suicide. __ True / False

i. Normal people don’t consider suicide. __ True / False

MULTIPLE CHOICE ANSWERS

5. There are a lot of myths and misconceptions about suicide. Respond to the following statements by circling either ‘True’ or ‘False’:

a. People who talk about killing themselves never do it. __ True / False

b. If someone tells you they have thoughts of suicide you are bound by confidentiality and can’t tell anyone. __ True / False

c. In Australia, the highest risk of suicide occurs in men in their 30s and 40s. __ True / False

d. If someone wants to end their life, there’s nothing you can do to stop them. __ True / False

e. Undiagnosed or untreated mental illnesses are the most common risk factor for suicide. __ True / False

f. Aboriginal and Torres Strait Islander people are twice as likely as non-Indigenous people to take their own lives. __ True / False

g. Men are four times more likely to die by suicide than women. __ True / False

h. More people die from road deaths than from suicide. __ True / False

i. Normal people don’t consider suicide. __ True / False
People living in non-metropolitan areas are more likely to die by suicide than those living in capital cities (ibid.). (p.20)

Although the rate of suicide among serving defence force personnel is reported as being slightly lower than the general population, the risk of suicide is found in some studies to rise over time for armed forces veterans (ibid.). (p.20)

As many as 70% of those diagnosed with cancer think about suicide during the 3 months after diagnosis (ibid.). (p.21)

In a Queensland study, 63% of those who have survived a suicide attempt report that they have not attended any mental health service or professional (ibid.). (p.21)

Suicide is the leading cause of death for Australians aged between 15 and 44 (Lifeline, Preventing suicide). (p.28)

Estimates from research (Botha et al; 2009) are that around 21,000 people throughout Australia are impacted by another’s suicide each year (ibid.). (p.30)

Persons identifying as lesbian, gay, bisexual, transgender and intersex (LGBTI) are estimated to at least 3.5 times more often die by suicide (ibid.). (p.31)

Discrimination on the basis of race, sexual preference, gender or disability heightens risks of suicide for some individuals (ibid.). (p.31)

Each year the highest numbers of suicides occur in working age adults, predominantly men aged 35-50 years. (swYtch, Suicide prevention: Taking a new approach). (p.32)

Over the last decade some 65-70% of suicides were in people between the ages of 25 and 60 years and 4 out of 5 of those people were men (ibid.). (p.32)

Feelings of hopelessness and thoughts of suicide can be much worse following very stressful experiences, such as a relationship breakup or traumatic life event, feeling totally alone and without any friends or family, grief after the death of someone close, losing a job or failing a big exam (Beyond Blue Ltd, Suicide Prevention: Knowing the signs). (p.39)

A common experience for people after a suicide attempt is fatigue and physical exhaustion (On the Line Australia Inc, After a suicide attempt). (p.47)

Around 2,000 Australians die from suicide every year. Some estimates suggest that around 1 in 4 people knew someone who took their own life (Better Health Channel, Suicide – family and friends). (p.49)

Even though suicide is, unfortunately, something many people are touched by, the social taboo surrounding this issue often means that family and friends may feel stigmatised and isolated (ibid.). (p.49)
**Attempted suicide**
Non-fatal self-injury with the intention of causing death. It should be noted people have varying degrees of intention to kill themselves, or self-harm.

**Bereaved by suicide**
The term used to refer to those who have had significant others die through suicide (e.g. partners, family, friends, classmates and workmates). These people are also referred to as ‘survivors’.

**Bereavement**
Refers to the loss of a close relationship through death. Grief is an individual’s emotional response to the death, and mourning is the social expression of that grief.

**Deliberate self-harm**
Also called self-harm and self-injury, it occurs when you deliberately inflict physical harm on yourself, usually in secret. It is not necessarily a suicide attempt and most commonly deliberate self-harm is a behaviour that is used to cope with difficult or painful feelings.

**Help seeking**
The process of an individual asking for help or support in order to cope with adverse life events or other difficult circumstances.

**Intervention**
To take action or provide a service to produce an outcome or modify a situation. Also, any action taken to improve health or change the course of, or treat, a disease or dysfunctional behaviour.

**Mental disorder**
A recognised, medically diagnosable illness or disorder that results in significant impairment of thinking and emotional abilities in an individual – intervention may be required. There are many different categories of mental disorder.

**Postvention**
The term given to activities and programs that are intended to assist those who have been bereaved by suicide to cope with what has happened. Suicide prevention and postvention are closely related in that postvention can also prevent further deaths.

**Resilience**
The ability to bounce back after experiencing trauma or stress, and learn and grow through both positive and negative experiences of life, turning potentially traumatic experiences into constructive ones. Factors that contribute to resilience include personal coping skills and strategies for dealing with adversity, such as problem-solving, cognitive and emotional skills, communication skills and help-seeking behaviours.

**Risk factors**
Factors such as biological, psychological, social and cultural agents that are associated with suicide and suicide ideation. Risk factors can be defined as either distal (internal factors, such as genetic or neurochemical factors) or proximal (external factors, such as life events or the availability of lethal means).

**Safety plan**
A plan created in consultation with a counsellor or doctor, that you can follow should suicidal thoughts return. When creating a safety plan, it is important to be as honest as you can to ensure you are comfortable with the plan and it meets your needs.

**Self-harm**
Self-harm is when an individual deliberately hurts or mutilates their body without the intent of suicide. There are many different types of behaviours that can be considered self-harming, including self-cutting, self-poisoning and self-burning. There are many reasons why someone may self-harm including a cry for help, a way of coping with stress, a symptom of a mental illness like depression, and/or it may show someone is thinking of suicide. Self-harming is a behaviour and not a mental illness.

**Self-injury**
Sometimes called non-suicidal self-injury, self-inflicted injuries or self-harm.

**Suicidal behaviour**
Includes the spectrum of activities related to suicide and self-harm including suicidal thinking, self-harming behaviours not aimed at causing death and suicide attempts.

**Suicidal ideation**
Thoughts about attempting or completing suicide.

**Suicide**
The act of deliberately causing one’s own death. For suicide to be officially recognised as such, a coroner’s ruling of suicide must be made.

**Suicide contagion**
The process whereby one suicide or suicidal act within a school, community, or geographical area increases the likelihood that others will attempt or complete suicide.

**Suicide prevention**
Actions or initiatives to reduce the risk of suicide among populations or specific target groups.

**Tipping point**
The point at which a person's risk of suicide increases due to the occurrence of some precipitating event, such as a negative life event or an increase in symptoms of a mental disorder.

**Warning signs**
Behaviours that indicate a possible increased risk of suicide, such as giving away possessions, talking about suicide or withdrawing from family, friends and normal activities.
**Websites with further information on the topic**

beyondblue  [www.beyondblue.org.au](http://www.beyondblue.org.au)
Black Dog Institute  [www.blackdoginstitute.org.au](http://www.blackdoginstitute.org.au)
Community Action for the Prevention of Suicide  [www.caps.org.au](http://www.caps.org.au)
headspace  [www.headspace.org.au](http://www.headspace.org.au)
Lifeline  [www.lifeline.org.au](http://www.lifeline.org.au)
MensLine Australia  [www.mensline.org.au](http://www.mensline.org.au)
Mindframe Media  [www.mindframe-media.info](http://www.mindframe-media.info)
ReachOut.com  [http://au.reachout.com](http://au.reachout.com)
SANE Australia  [www.sane.org](http://www.sane.org)
Suicide Call Back Service  [www.suicidecallbackservice.org.au](http://www.suicidecallbackservice.org.au)
Suicide Prevention Australia  [http://suicidepreventionaust.org](http://suicidepreventionaust.org)
SuicideLine  [www.suicideline.org.au](http://www.suicideline.org.au)
Youth Beyond Blue  [www.youthbeyondblue.com](http://www.youthbeyondblue.com)

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**THANK YOU**
- Headspace
- Better Health Channel
- Suicide Call Back Service
- National Mental Health Commission.

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