Suicide in Australia – An analysis of Mental Health Promotion Programs and the Nurse's Role in Suicide Prevention

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Introduction

Suicides are a significant matter of concern to national authorities as well as communities as they represent a potentially avoidable form of death. In a large majority of the cases, suicides signal a major underlying mental and/or emotional issue such as abuse, depression, or deep-rooted insecurity. This paper aims to throw light on suicides in Australia including statistics, population groups in Australia that are most vulnerable to committing suicides, its risk factors, and protective factors. It also describes two important mental health programs in Australia that work for the prevention of suicides and treatment of vulnerable people. Finally, it reflects on the role of the nurse in suicide prevention in their healthcare facility setting and in the community setting.

Definition of Suicide

According to the World Health Organisation (2015), suicide refers to the act of intentionally taking one's life. In the International Classification of Diseases, deaths related to suicide are categorised under Intentional Self-Harm (X60-X84) (World Health Organisation, 2006). However, this category could also include deaths where the practice of self-harm was not intended to result in death (Henley and Harrison, 2015). According to nationally agreed definitions, deaths due to suicide are considered potentially avoidable by means of provision of individualised care or hospital-based care (AIHW, 2015).

Population Groups Susceptible to Suicide

In Australia, males are more likely to commit suicide than females. Statistically, 75% of all suicides are committed by males and the mortality rate for the age group of 20 to 74 years is about 3 to 4 times higher for males than for femlaes. Annually, the number of suicide deaths for

males is 20 per population of 100,000, and the number of suicide deaths for females is 5 per population of 100,000. The most number of suicide cases are found in the age bracket of 40 to 49 years for males, and in the age brackets of 40 to 44 years and 50 to 54 years for females. Despite the suicide rate being higher for males than females, it has been found that females are more likely to engage in self-harm practices especially in their teenage years as evident by high hospitalisation rates for self-harm in females (Harrison and Henley, 2014). Another report by Kinchin and Doran (2018) revealed that suicide is the most common cause of death in the age group of 15 to 24 years, equating to an average of 319 suicide deaths annually. In a population of 100,000, this statistic equates to an average number of suicides of 11.6 (Kinchin and Doran, 2018).

According to a report by Suicide Prevention Australia (n.d.), the number of suicides has significantly increased in the past two decades. In the year 2017, the number of suicide deaths in Australia was 3,128, which means that the per day average of suicide deaths was more than 8. Also, this number is higher than the number of suicide deaths in 2016 which was 2,866. Considering incidents of self-harm which do not end in death, around 65,000 people in Australia are reported to attempt to take their lives every year. This brings the per day average of reported self-harm incidents to more than 180. Apart from the person who directly suffers injury and/or death, it has been estimated that an average of 125 additional persons are affected by each suicide incident in terms of suffering from grief, trauma, and loss. Also, the financial burden of suicides is quite high in Australia amounting to around 6 billion USD annually (Suicide Prevention Australia, n.d.).

Considering specific community groups that are more likely to commit suicide, Aboriginals, Torres Strait Islanders, people who live in remote areas and very remote areas are

more likely to commit suicide than other community groups in the Australian population (Harrison and Henley, 2015). In 2017, the number of suicide deaths amongst the Aboriginals and Torres Strait Islanders was found to be two times higher than the number of suicide deaths among the non-Indigenous communities, and this statistic has been found to be consistent over the years (Suicide Prevention Australia, n.d.).

Another community that is susceptible to suicides is the LGBT community in Australia, although there is not much research to support this fact. A study conducted by Jorm et al. (2002) found that the LGBT population was much more sucesptible to developing mood and anxiety disorders as compared to the normal population. The reasons for this have been proposed to be gender role non-conformity and abuse in childhood that leads to suicidal tendencies in LGBT adults (Ploderl and Fartacek, 2007). Yet another study has pointed to a possible role of heavy substance abuse and related mental health conditions as a cause for suicidal tendencies in sexual minority women (Hughes et al., 2010). Another population that is susceptible to suicide is people afflicted with HIV/AIDS which can be attributed to substance abuse, mental health conditions, and other chronic conditions that result in suicial behaviours in this population (Komiti et al., 2001).

Risk Factors of Suicide

The risk factors for suicide may include psychological, social, and biological factors that may result in a person having mental health issues, a tendency to consume drugs, and a tendency to practice self-harm (AIHW, 2015). At the individual level, the risk factors for suicide include deteriorating physical and mental health, low self-esteem, difficulty in coping with stress, and inability to deal with extreme circumstances. Social risk factors include those that involve

unfulfilling relationships with family, friends, and colleagues, thereby questioning a person's sense of self-worth and belonging. Apart from these, there are other broader-level risk factors at the political, cultural, economic, and environmental level that indirectly contribute to a person's quality of life (Commonwealth of Australia, 2008).

In the Indigenous population specifically, alcohol abuse and drug abuse have been identified as significant risk factors for committing suicide (Senate Community Affairs References Committee, 2010). These people have been through severe intergenerational trauma that has taken a heavy toll on their physical, mental, and emotional health. Many people have lost their families, children have lost their childhood, and workers have lost their jobs resulting in increased levels of stress in this population. Indigenous people who are not able to access healthcare and support services to deal with their health and life issues, over time, become much more vulnerable to committing suicides (Dudgeon et al., 2017).

Protective Factors of Suicide

Protective factors for suicide include receiving appropriate care for mental and physical conditions, receiving treatment for substance abuse and alcohol abuse, receiving social support servcies, and getting employed (Melvin et al., 2015). Out of all these factors, social support has been proven to be the most effective in preventing suicides in vulnerable populations. This type of support can be in the form of public awareness campaigns that are targeted at addressing risk factors and stigma associated with suicide, providing information regarding support services, and encouraging vulnerable people to seek help and/or social connections. Some examples of organisations that provide this type of suicide prevention services include Lifeline and beyondblue (Kleiman and Liu, 2013).

Impacts of Suicide

Suicide of a loved one has a tremendous impact on the family members in terms of instilling negative emotions such as guilt, grief, and remorse that stays with them throughout their lives. As a result, suicide of a family member can affect the quality of lives of all people who were close to the deceased. As estimated, the number of people that a suicide affects, on average, is 6 individuals. Suicide also affects the family members' social lives as they are not ready for social encounters and the stigma associated with suicide prevents other individuals from the community from approaching them freely (Comans et al., 2013).

Mental Health Promotion Programs for Suicide Prevention in Australia

1. National Suicide Prevention Strategy (NSPS)

The National Suicide Prevention Strategy (NSPS) was initiated in 1999 and it replaced the National Youth Suicide Prevention Strategy (NYSPS) to expand the targeted age groups of the program. This strategy has been developed and operated by the Living Is For Everyone (LIFE) framework and is funded by the Australian Government (Commonwealth Department of Health and Aged Care, 2000).

This strategy takes a population health approach for preventing suicides by adapting specific mental health strategies to suicide prevention in Australia. It divides the communities into different target groups based on risk factors and introduces interventions to counter the risk factors with protective factors. Its interventions typically target those sub-groups of the population that are not yet exhibiting suicidal tendencies, but that are exposed to one or more suicide risk factors that may predispose them to commit suicide in the future. These sub-groups

that are targeted are enlisted either through screening programs or referred by mental healthcare providers (Robinson et al., 2006).

Apart from selective interventions, it also promotes universal interventions that seek to reduce suicide risk factors and promote protective factors at a population level. Some examples of universal interventions practiced by the NSPS are restricting access to ways by which suicide can be committed, conducting community programs, and providing suicide-related information in the media. People who are specifically identified either by selective interventions or universal interventions as vulnerable to committing suicide are provided with psychotherapy and other relevant support services (Department of Health, 2014).

Based on current Australia statistics regarding suicide, the LIFE Framework has formulated 6 Action Areas as part of the NSPS. The first one is to understand the risk and protective factors of suicide at the population level and to improve the evidence base for prevention of suicides in vulnerable populations. The second one is to develop general health, well-being, and resilience in people and instill in them the capacity to take care of themselves. The third area is to build a strong community that can recognise and eliminate risk factors of suicide in their communities. The fourth area is to identify and connect relevant local organisations and form appropriate partnerships so that every region in Australia is covered by suicide prevention care. The fifth one involves identifying people and/or groups that are most at risk of committing suicide and promoting interventions to eliminate the risk factors and provide support. The sixth and final one is to establish quality standards throughout the country so that every person experiences the same quality of care (Martin and Page, 2009).

The NSPS is one of the first suicide prevention programs globally and has served to place Australia on the map for being a pioneer in this field. The LIFE framework as well as NSPS is a robust policy and program framework that has adapted its suicide prevention strategies for different target groups exposed to different risk factors throughout the country. It has also increased accessibility for people with mental health issues to seek timely care at recognised healthcare centres (Robinson et al., 2006).

2. National Aboriginal and Torres Strait Islander Suicide Prevention Strategy

This strategy specifically targets the Indigenous population of Australia by identifying the risk factors and impact of suicide, and promoting targeted interventions for this community. It considers the culturally specific perceptions of the indigenous population with regards to mental, physical, emotional, and spiritual health, and devises interventions that align with their principles and beliefs. It focuses on promoting community-based interventions and integrated approaches to suicide prevention within the indigenous community. It also works closely works with the government to develop culturally relevant interventions and strategies that are targeted to vulnerable people in the Aboriginals and Torres Strait Islander population (Department of Health, 2014).

Similar to the NSPS, this strategy too has several key Action Areas that guides its founding vision and principles. The first one is to build capacity and strength within the indigenous population so that the resilience to suicide of the entire community is increased. This can be achieved by people within the community taking on leadership roles and by promoting useful and specific interventions pertaining to the risk factors within this community. The second area is to target individual members of this community, assess their suicide risks, and implement

the necessary interventions. For the indigenous population, most people face difficulties during their childhood which programs their thoughts and self-esteem forever. Therefore, this strategy implements universal interventions in schools and healthcare centres specific to this community to identify and assess people at a high suicide risk. The third area is to provide specific suicide prevention services to individuals particularly those who have been through mental and emotional trauma, people who have been discharged from prison, and people with histories of physical abuse, substance and alcohol abuse, and attempted self-harm. The fourth one aims to bring together different governmental and non-governmental institutions to form part of a coordinated approach to suicide prevention in the indigenous community. The fifth and sixth action areas are to develop a targeted evidence base which provides high quality suicide prevention information and spreads it among the indigenous communities (Department of Health and Ageing, 2013).

Suicide prevention is a major challenge in the Aboriginals and Torres Strait Islander communities because of the high rates of trauma, history of abuse, unemployment, and economic inequalities as compared to the non-indigenous population. Therefore, suicide prevention strategies need to be much more strong and specific for these communities. Although this strategy has gone a long way in helping individuals recover from their mental and emotional trauma, there are still several reports that suggest high levels of dissatisfaction in this community (Milroy et al., 2017). Therefore, suicide prevention strategies for this community need to implement research-based strategies and involve people from the indigenous community so as to increase accessibility and likelihood of using these services by vulnerable people.

Role of Nurse in Suicide Prevention

It has been found that a majority of people who commit suicide have had a health visit within one month prior to their death (Luoma et al., 2002). Therefore, targeting mental healthcare facilities to identify and assess patients who are at an increased risk of suicide has been considered a wise step in suicide prevention initiatives (Mann et al., 2005). As registered nurses are the ones who are most in contact with patients, enhancing their knowledge about the risk factors of suicide and their prevention strategies can help predict and avoid a large number of suicide deaths (Berlim et al., 2007).

The first step to suicide prevention in a healthcare setting is to carry out a suicide risk assessment that considers standard risk factors, and observable signs in a patient that may involve both speech and body language. If a suicide risk is perceived, the nurse should spend more time with the patient in uncovering more details about current situation and past history. As nurses provide a majority of direct care services to patients, they are better placed to identify the warning signs of suicide and escalate the matter to the relevant authorities. They may do so through vigilant observation, recognition of risk factors, and gathering relevant information (Hagen et al., 2017).

One of the most important interventions that can be implemented by a nurse is to develop a close relationship with a potentially suicidal patient. This will help the patient develop a sense of belonging and self-esteem, and move from a death-oriented place to a life-oriented place. Once the patient becomes comfortable and open to conversation, the nurse needs to identify risk factors that may predispose the patient to committing suicide. Once the nurse acquires this information, the family members may be involved and/or the patient may be referred to a psychotherapist for implementing the necessary interventions. This initial risk assessment and

early intervention on the part of the nurse can go a long way in recognising vulnerable people and preventing a large number of suicide deaths (Cutcliffe and Barker, 2002).

Conclusion

In conclusion, suicide is a complex mental health concern that plagues every part of the world and poses a huge challenge to identify and prevent it in a timely manner. In Australia, the number of suicide deaths is quite high and it has been on the rise over the past two decades. Males, adolescents, middle-aged, and indigenous communities are at a much higher risk of suicides as compared to other groups. Australia is one of the pioneering nations in leading several mental health promotion and suicide prevention programs for different communities by identifying risk factors and implementing interventions. These strategies work at a population level and involve several local and regional organisations in performing targeted screening of vulnerable populations. Finally, as most people who commit suicide have deep-rooted mental health issues, healthcare providers and nurses are appropriately placed to identify at-risk individuals and treat them appropriately.

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