POSITION STATEMENT
Overcoming the Stigma of Suicide

Suicide Prevention Australia
September 2010

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About Suicide Prevention Australia

Suicide Prevention Australia (SPA) is a non-profit, community organisation working as a public health advocate in suicide and self-harm prevention, intervention and postvention. SPA is the only national umbrella body active in suicide prevention throughout Australia, promoting:

- Community awareness and advocacy;
- Collaboration and partnerships between communities, practitioners, research and industry;
- Information access and sharing; and
- Local, regional and national forums, conferences and events.

As a national organisation, SPA supports and assists both individuals and organisations throughout Australia, by promoting collaboration and partnerships in suicide prevention, intervention and postvention. SPA is supported by funding from the Australian Government under the National Suicide Prevention Strategy.

SPA Position Statements

SPA regularly publishes position statements on priority areas of suicide and self-harm prevention, intervention and postvention in Australia. These foundation documents provide a basis for understanding, discussion, teaching, delivery and research, and reflect the diversity of voices within the sector.

They are not intended to be specific to or limited to policy-makers alone, but are instead written with a general cross-section of the educated lay public in mind (i.e. broader community, media, and other NGOs). SPA Position Statements therefore represent a starting point for policy and strategy development, while supporting SPA’s ongoing advocacy work and activities.

These documents are developed in close consultation with community and specialist reference groups and are ratified by the SPA Board. They are reviewed biannually with the intention of being reaffirmed, revised or retired, and generally do not refer to issues previously covered by other SPA Position Statements or by those currently in the process of being drafted.

The development of SPA Position Statements is supported by the Australian Government as part of its funding agreement with SPA. Position statements support and build on the Living Is For Everyone (LIFE) Framework developed under the National Suicide Prevention Strategy.

SPA Position Statements can be downloaded from the SPA website:
http://www.suicidepreventionaust.org/PositionStatements.aspx

Acknowledgments

SPA acknowledges the advice, support and involvement of those individuals and groups that contributed to the development of this position statement. Appreciation is particularly expressed to those who, through their participation, provided invaluable knowledge, expertise and experience. This includes members of the Overcoming the Stigma of Suicide SPA Reference Group, co-chaired by Barbara Hocking, Executive Director of SANE Australia, and Dr Michael Dudley, Chairperson of SPA. Gratitude is also extended to those who took part in the broader community consultation process or contributed independently via direct dialogue with SPA and its representatives.

SPA also acknowledges and appreciates the ongoing contributions of the SPA Board and staff, particularly Chairperson, Dr Michael Dudley, and CEO, Ryan McGlaughlin. Thanks are also expressed to SPA Research and Policy Development Coordinator, Sara Maxwell, for her assistance in researching and writing the position statement, and to Katrina Clifford for her sub-editing of the draft document.
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To access accurate information about suicide and the portrayal of suicide in the media, please visit: http://www.mindframe-media.info/

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Introduction

Suicide attracts a unique kind of stigma, which impacts on people with lived experience of suicide by damaging social relationships and removing help seeking avenues for those in need. This stigma can and should be challenged and reduced in a safe and compassionate way. By reducing the stigma of suicide, through open dialogue and increased discussion and understanding, the whole of the community can become involved in its prevention and improve the lives of those affected. Currently, the stigma of suicide continues to inhibit suicide prevention efforts and inflict suffering on those with lived experience of suicide.

“It is not yet acceptable in our society to tackle suicide head on. Suicide continues to live in the shadows and whilst it does it will continue to claim unnecessary lives.” [Quote from a person bereaved by suicide, extracted from SPA’s Personal Story Submission to the Senate Inquiry into Suicide in Australia (2009c)]

“By attaching stigma to the act of suicide we further compound the isolation they feel, create barriers to discussion/disclosure with the doctor or confidant and decrease the likelihood of help-seeking.” [Quote from Suicide Bereavement Support Group Facilitator during consultation for this Position Statement]

“Worldwide, the prevention of suicide has not been adequately addressed due to a lack of awareness of suicide as a major problem and the taboo in many societies to openly discuss it.” [Quote from World Health Organization http://www.who.int/mental_health/prevention/suicide/suicideprevent/en/]

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.

Despite this, there have been no comprehensive measures taken to improve this situation nationally. SPA has produced this position statement to examine the origins and impacts of the stigma and, applying knowledge of suicide (much of it from those with lived experience), proposes that the stigma of suicide can and should be challenged and reduced.

What is stigma?

The term stigma comes from Greek origins, meaning a mark or tattoo that was typically inflicted on a slave or prisoner to distinguish them from others. Stigma refers to the social disapproval of individuals or groups due to a discredited characteristic that distinguishes them from others. Among the most quoted definitions of stigma are those of Erving Goffman. Writing in 1963 in Stigma: Notes on the Management of Spoiled Identity, Goffman described the source of stigma as “an attribute that is deeply discrediting” (1963: 3), tainting and labelling an individual and thereby spoiling their normal identity. Stigma is typically “characterised by exclusion, rejection, blame or devaluation” (Weiss & Ramakrishna 2004: 13).

Culture and socialisation play a crucial role in how stigma is constructed and understood. Stigma can be seen at an individual, community and service level, and the terms used to describe stigma and its meaning may also be different. These may include: discrimination, shame and taboo (MMHA 2008).

Corrigan (2005) and Thornicroft et al. (2007) map stigma as a problem of knowledge (ignorance), attitudes (prejudice) and behaviour (discrimination).

Ignorance about the causes of suicide often leads to its stigma; evident in negative attitudes and discrimination encountered and perceived by those with lived experience. This includes the individual, carers, friends, family and service providers.
Why is suicide stigmatised?

Stigma is a social construct and, in this sense, is influenced by social learning and cultural backgrounds. Suicide as a stigmatised issue has a long history with religious origins (Retterstol 1998). Although references to suicide in the Bible are presented in descriptive not judgmental tones, by the 4th Century, religious doctrine consigned suicide to the category of ‘mortal sin’. Throughout the Middle Ages, Christianity, Judaism and Islam all regarded life as a gift from God. Therefore, suicide was considered self-murder and a sin against God’s will. People who died by suicide were denied funerals and burials, and bereaved families were regularly ostracised as a result of stigma. Suicide was also a crime in some countries; the inheritance of the deceased could be confiscated and people who attempted suicide faced imprisonment and punishment. Operating as primitive forms of suicide prevention, these attitudes continued into the 20th Century. Although such condemnation of suicide is rare now, the legacy of its sinful and criminal status remains embedded in social attitudes. This is evident and perpetuated by the widespread use of the term ‘committed’ when referring to suicide. SPA hopes that increased suicide awareness will remove this term from common language.

The continuing stigma ingrained in social and cultural attitudes towards suicide is the manifestation of persistent misunderstandings about the causes of suicide. Suicide is often misconstrued as a ‘personal weakness’ or a ‘selfish’ or ‘cowardly’ act. An alternative and equally incorrect view is that suicide is not preventable and that those who die by or attempt suicide are beyond help due to a mental illness or life crisis. These views translate into negative attitudes that stereotype people who attempt or die by suicide as inherently different to others.

Unlike parallel health issues such as HIV/AIDS and even mental illness, suicide is an issue that has seen little if any reduction in its associated stigma (Sudak et al. 2008). One possible explanation for the pervasive power of suicide stigma can be found in Corrigan’s (2005) and Thornicroft et al’s (2007) problem of knowledge. There is little understanding of suicide in the community, and consequently personal attitudes are generally based on assumptions and myths. Actions such as suicidal behaviour, which are perceived as voluntary, are subject to greater stigma and less forgiveness than those actions which are perceived as involuntary (Link & Phelan 2001; Falk 2001). Thus, the (inaccurate) perception that suicide is a ‘free choice’ or ‘solution’ to a problem, creates a distinction between suicide and other health issues that are often perceived as ‘uncontrollable’ – for example, mental illness. The occurrence of suicide in individuals without diagnosed clinical disorders is misconceived as a character flaw or personal failure, rather than a tragedy of social and possibly psychiatric origins. Accordingly, continuing ignorance about the aetiology of suicide contributes to its stigma.

In recent years, there have been many medical and social advancements and discoveries that have contributed to improved understanding of the causes (and preventions) of suicide. Despite this, there continues to be very little public discussion of suicide (largely due to stigma, fear of contagion affects and lack of sector communication resources). Therefore, this information generally remains with medical specialists and suicide prevention experts and does not permeate into the community.

The impacts of suicide stigma

There has been very little analysis of the prevalence or impact of suicide stigma in Australian society, however anecdotal evidence and accounts from those affected by suicide suggest that stigma adds a significant burden to their experiences of suicide. Suicide remains a taboo subject in our society, and it is often viewed with suspicion and a mark of inferiority. People who have thoughts about or have attempted suicide are often considered irrational or dangerous; causing them to be excluded from social interaction and even feared (Joiner 2010). While fear of suicide itself is an important protective factor for vulnerable individuals, the social fear of a person ‘tainted’ by suicide needs to be challenged.

People with lived experience of suicide report internalising feelings of indignity and shame, caused by their perception of how others view them. This ‘self-stigma’ can have the impact of a self-fulfilling prophecy; people expect to be treated differently so they modify their behaviour, even in the absence of discrimination, which reinforces the perception that they are ‘different’.

It must be noted that not everyone with lived experience of suicide encounters stigma and many find the reactions and support that they receive are beneficial and conducive to their recovery or grieving process. Research conducted by SANE Australia, involving people with a mental illness, found that 73% of respondents had talked to someone about their suicidal thoughts, despite finding it difficult. For 59% of these individuals, this had led to them getting help (SANE Australia 2010).
Notwithstanding this, in its most extreme form, stigma can cause concrete forms of social inequality, especially in terms of access to resources and networks. Disadvantages in terms of income and health care have been regularly cited as an impact of the stigma associated with mental illness (Smith 2002; Link & Phelan 2001; Weiss & Ramakrishna 2004; Major & O’Brien 2005; Ping Tsao et al. 2008); causing damage to self-esteem and contributing to the psychological burden of mental illness (Corrigan et al. 2006). Those who suffer under the stigma of suicide are vulnerable to similar consequences; experiencing real and perceived discrimination in terms of social inclusion and networks, income, and health opportunities.

Stigma can be individual or institutional. For example, the stigma of suicide (closely related to the stigma of mental illness) can lead a stigmatised individual to hide how they are feeling and to avoid help-seeking in an attempt to retreat from their discredited attributes (Smith 2002). This is especially prevalent for men, who die by suicide at much higher rates than women, and is also influenced by cultural understandings and acceptance of services. Furthermore, at an institutional and societal level, the stigma of suicide may contribute to a disregard towards and under-resourcing of help-providing services (Campbell & Deacon 2006). Stigma can therefore be so powerful that it pervades all levels of society, often outside of conscious awareness, and can become an integral part of systems, standards, institutions and legislation (Smith 2002).

The stigma of suicide also impacts on the coronial reporting of deaths and the subsequent suicide statistics used to create public awareness and inform policy. The Senate Inquiry into Suicide in Australia heard evidence to suggest that real and perceived pressure is put on coroners by families and communities to influence their findings on the cause of death of a deceased person (Senate of Australia 2010: 25-26). This was attributed to cultural and religious beliefs and the fear that a suicide finding would stigmatise the family of the deceased. The impact of this pressure and social stigma on coronial reports is hard to quantify, but it is expected to be more prevalent in rural communities and when the deceased is a young person (De Leo et al. 2010).

The stigma of those bereaved by suicide

Empirical research is divided on whether or not suicide bereavement is significantly different to other forms of traumatic death (Sudak et al. 2008; Čvinar 2005; Clark & Goldney 1995; Sveen & Walby 2008; Begley & Quayle 2007). What is not disputed is the reaction of others to those bereaved by suicide and the subsequent stigma that this places on the bereaved. In a review of studies on suicide bereavement, Sveen & Walby (2008) conclude that people bereaved by suicide report levels of rejection, shame and blame that are higher than other bereaved people. Begley & Quayle (2007) attribute the stigma experienced by those bereaved by suicide to the uneasy social interactions following the death of a loved one, rather than a person’s actual experience of the death, and report that this gets worse with time. This is supported by Thomas Joiner’s reflections on his father’s suicide: “My feelings about suicide stem partly from people’s reactions to my dad’s death” (Joiner 2005: 1). He continues to describe how many people were so preoccupied with their misunderstandings of suicide that their usually generous and compassionate interactions were replaced by awkwardness and avoidance following the death (Joiner 2005).

Research by Maple et al. (2010) found that following the suicide of a child, parents felt ‘silenced’ by others’ reactions, and that this inhibited their grieving process. Social conventions “that do exist (for discussing suicide) encourage the position that suicide is neither acceptable, appropriate nor justifiable, avoiding recognition of the event” (Maple et al. 2010: 247). Similarly, Ratnarajah & Schofield found that children bereaved by their parent’s suicide felt shamed and criticised by others, which consequently had “major negative impacts on the family’s sense of security with the social network” (2008: 626). The long-term impacts of this stigma, including personal, financial and health effects, can often be under-estimated by society and the ongoing healing of the bereaved can be left unsupported.

Feigelman et al. (2009) found that the heightened grief and distress caused by the difficulties in interpersonal relationships following a suicide death put the bereaved at risk of depression and suicidal thinking. This is reflected in the LIFE Framework (Commonwealth of Australia 2008), which recognises suicide bereavement as a risk factor and a tipping point for further suicides.

Many people bereaved by suicide also avoid disclosing their loved one’s cause of death due to the social reactions that they expect or have experienced from others. This further contributes to the lack of awareness of suicide in our community.
Stigma as a cause of suicide

Connectedness and a sense of belonging (in whatever form) are inherent to individual wellbeing. The impact of stigma threatens social connectedness and distances those who are stigmatised from others. In this way, the stigma of any attribute – such as homosexuality, minority ethnicity or criminality – can be detrimental to the individual involved. The high levels of suicide among the gay, lesbian, bisexual, transgender and intersex (GLBTI) community (SPA 2009a; Clements-Nolle et al. 2006), culturally and linguistically diverse (CALD) communities, including Indigenous Australians (SPA 2008), and among incarcerated individuals (World Health Organisation 2007), may relate to how these individuals are treated by others or how they perceive they are viewed and treated. For example, it has been suggested that people from CALD communities suffer a double disadvantage when they are stigmatised in the mainstream community for being from an ethnic minority and then stigmatised again for experiencing a mental health issue or suicidality (MMHA 2008).

The stigma of some mental illnesses, although dissipating as a consequence of community mobilisation and some successful awareness campaigns, still remains (Jorm et al. 2005; SANE Australia 2009). This stigma is a huge barrier to help-seeking and disclosure; thereby greatly increasing suicide risk for people with mental illness (Pompili et al. 2003; Eagles et al. 2003). A lack of compassion and levels of misunderstanding in the community, and even within the medical and social professions, can reduce potential care avenues. Help-seeking is especially restricted for men and young people, who value self-reliance and may therefore experience a sense of shame about needing help for mental health issues (Gilchris & Sullivan 2006).

The stigma of suicidality, suicide attempts or suicide bereavement adds considerably to the burden on the individual(s) concerned. The high levels of suicide among people who have previously attempted suicide and those bereaved by suicide must be understood in terms of both the personal and social impact of their experiences (Hawton & Harriss 2007). The internalised feelings of guilt and shame, and the perception that others view them negatively or do not understand their feelings, can greatly contribute to the distress and indignity of those with lived experience of suicide (SPA 2009b; Feigelman et al. 2009).

Individuals experiencing stigma (of any attribute) may be at risk of suicide. Health professionals, family and community members should be aware of the risks and counteract these with appropriate care. Stigma reduction measures in areas such as homosexuality and mental illness must be pursued to remove unnecessary risk.

Suicide stigma and the Australian experience

Australia has not had a widespread suicide stigma reduction campaign. While campaigns regarding mental illness have been more prevalent in the last decade, even these have mostly been provided by non-government organisations and have focused on recognising signs of mental illness and promoting help-seeking as opposed to specific stigma reduction objectives. However, several targeted or localised suicide prevention, awareness and stigma reduction programs have been initiated. In 2003, the International Association for Suicide Prevention and the World Health Organisation initiated World Suicide Prevention Day (WSPD) to be held every year on 10 September. SPA has celebrated WSPD in Australia since 2004 by bringing the community together to create dialogue and awareness of suicide prevention, reduce stigma, and mobilise action. By hosting successful events, such as the Life Awards and Community Forums, SPA has engaged with the community and the sector and used WSPD as a mechanism for change.

However, limited by resource constraints, these events can currently only service a targeted group. With increased resources and capacity, SPA considers WSPD a prime opportunity to leverage community interest to create a comprehensive year-long national suicide stigma reduction campaign.

Stigma is also addressed through suicide prevention training such as ASIST (Applied Suicide Intervention Skills Training), safeTALK, suicideTALK, suicideCare, LifeForce, and Mental Health First Aid – programs that are provided by several NGOs and contribute to suicide understanding, stigma reduction and suicide prevention awareness among targeted groups. In March 2010, Lifeline Australia launched a Community Service Annunciation to raise awareness of suicide among the public, which ran on national television. Meanwhile, Mindframe and the SANE Media Centre target media depictions of suicide and mental illness with the intention of reducing stigmatised reporting and reducing inappropriate depictions of mental illness and suicide.

Other programs that focus on mental health stigma have suicide prevention as secondary objectives. These include MindMatters and KidsMatter, both of which raise awareness of mental illness among school children, and beyondblue's national depression awareness campaigns. R U OK? Day was initiated in 2009 and aims to encourage people to connect with others as a
means of suicide prevention through a national media campaign and day of action. Similarly, Multicultural Mental Health Australia (MMHA) has initiated a Stepping Out of the Shadows mental health stigma reduction campaign for CALD communities in an effort to increase help-seeking behaviours.

However, despite these commendable programs, suicide awareness and suicide prevention competence remain unacceptably low in Australian society.

In October 2009, SPA called for members of the public with experiences of suicide to submit their personal stories for inclusion in SPA’s submission to the Senate Inquiry into Suicide in Australia (2009c). SPA received nearly 100 diverse personal stories in a two-week period, within which the stigma of suicide was repeatedly referenced as a major issue.

These personal stories document the experiences of people who have attempted or are bereaved by suicide, as well as carers of people who are suicidal. The following are a collection of quotes from contributors that describe how stigma impacts those with lived experience of suicide:*'

'shame, guilt, intense embarrassment, humiliating, taboo, we deserve services and support like everyone else, burn in hell, value judgments, misconception and conjuncture, awareness in the public is woeful, loneliness, prevents bereaved people from being able to share their feelings, get over it and get on with it, family stayed away, difficult to broach the subject, makes people very, very uncomfortable, avoid topic at all costs, crime, don’t want to talk, ignored, devalues life, difficult to approach someone, afraid of suicide, afraid that speaking of suicide will bring the tragedy into their own lives, shameful stigma, clam up, careful and guarded, weakened, white elephant in the room, suicide lives in the shadows, looked down on, myths about suicide need addressing, stigma has developed over generations, people believe it is wrong to use the word, avoid talking about it, mental illness is seen as a non-disease, people avoid me, suicide is a taboo subject much like cancer was, close people don’t understand, angry, people do not talk openly, would not talk to kids about it, get rid of myths, NOT TALKED ABOUT, HIDDEN AWAY, suicide swept under the rug, hidden topic, people very unsure what to say or do, secret, darkness and shame, hide suicide in the cupboard, failure in themselves, see the deceased as weak, media fail to report, don’t want to talk about how or why, shame and secrecy, charged with attempting to murder themselves, sweeping it under the cover, distress and shame, situation is stupid and unhealthy, lack of openness, judgment, reserve'.
The personal stories also explored possible solutions to tackling stigma, including:

*stop hiding suicide from public view, people talking about it helps reduce stigma, vital that people are able to talk, school curriculum, community events and the media, restore dignity and self-worth, educate the community, we need to be informed, people can handle the truth about suicide, newspaper articles, more in the public domain, make suicide prevention more public, left a legacy to lessen stigma, there is no shame, need more opportunities to talk, word has got to be spoken of more, ambassador for suicide prevention, information night for parents, it needs to be talked about in a more open manner, create awareness, no longer can we deny it, the more you talk the more you connect, SUICIDE SHOULD NOT BE HIDDEN, IT IS TIME TO TALK, having our voices heard, we CAN bring suicide out of the darkness, community needs to be educated, let’s not hide the facts anymore, get into our schools and community and educate, talking openly improves awareness, ok to talk about suicide just as it’s ok to talk about cancer or road deaths, awareness, inform and de-stigmatising, against our interests to pretend it doesn’t happen, why the secrecy, why the taboo? Suicide demystified by lifting the veil of secrecy, open communication in schools’.

*(Please note: these are the opinions of those who contributed to SPA’s Personal Story Submission to the Senate Inquiry into Suicide in Australia, and do not necessarily represent SPA’s views).*

The stigma of suicide is also evident in the treatment options and experiences of people that are suicidal. SANE Australia research identified that the majority (80%) of people who received medical attention following a suicide attempt were not provided with a simple crisis plan of what to do if they felt suicidal in future (SANE Australia 2010). The under-funding of mental health services, the lack of avenues for crisis response to suicide, and the attitudes of some medical and social services to suicide attempters are manifestations of stigma at a service level.

(See SPA Position Statement, Crisis Response and the Role of the Emergency Services and First Responders to Suicide and Suicide Attempts, for more information.)

As previously mentioned, the stigma of suicide pervades all levels of society, including politics and bureaucracy. A well-publicised international example of bureaucratic suicide stigma is that of the Golden Gate Bridge in San Francisco, which loses over 50 people a year to suicide. Campaigns to build a barrier on the bridge (an evidence-based prevention measure) have been ignored for over 30 years on the grounds of aesthetics, engineering safety, and costs. During this time, tourist and cyclist safety measures have been implemented, despite no related deaths and similar aesthetic and cost implications. A recently approved safety net for the bridge has still not received any construction funding. Unlike cycling, suicide prevention is not sufficiently considered a public safety issue.

Similarly, The Gap in Sydney has been denied funding for evidence-based safety barriers to prevent the high numbers of suicides at the site each year. This has only recently received political attention, despite years of community advocacy. At the time of writing, these issues were yet to be resolved.

Mental illness and suicide prevention consistently experience less investment than parallel health areas, despite being leading causes of morbidity and mortality. In the 2004-05 financial year, 7.8% of Australia’s health budget was spent on mental health care, despite the fact that mental illness contributes to over 13% of the burden of disease in Australia (Australian Institute of Health and Welfare (AIHW) 2010: 429). There was a steady improvement in this ratio in the following years, but it was once again widened by the recent National Health and Hospitals Reform funding.
Suicide remains the leading cause of death for Australian men under 45 and women under 35 in Australia (AIHW 2010), yet only $22 million is currently spent on specific suicide prevention, intervention and postvention annually (Department of Health and Ageing (DoHA) 2009) [compared to $5.942 billion for cardiovascular disease in the 2004-05 financial year (AIHW 2010: 427)]. This demonstrates the top-down stigma of this preventable cause of death (for further evidence of this, see page 127 of http://www.aph.gov.au/Senate/committee/clac_ctte/suicide/submissions/sub65.pdf and a comparison of investments in road safety versus suicide prevention in Australia).

Media guidelines for suicide reporting

One avenue to disseminate information about suicide, to promote help-seeking, increase awareness and reduce stigma, is the media. Evidence-based research has shown the risks that flow from inappropriate and irresponsible media reporting of suicide (Pirkis and Blood 2010). Media reports that glamorise suicide or provide detailed information on the deceased or their method of death have been shown to have the potential to induce copycat and contagion suicides. To address this risk, the Australian Government funded the development and implementation of the Mindframe National Media Initiative and the SANE Media Centre, which provide resources, information and advice to media professionals and other sectors on how to responsibly report and portray suicide. This has had positive results in Australia, which has seen increased and improved quality of reporting (Pirkis et al. 2008). This needs to be supported by the frequent review and updating of media guidelines, in order to reflect current social standards and emerging research.

The media can play a part in dissipating the stigma associated with suicide, but only if information is presented in the right way. Morgan and Jorm (2009) found that news stories of mental illness disclosure by prominent public figures had a positive impact on reducing stigma in those youths who viewed them. This was in contrast to news stories that depicted crime and violence in relation to mental illness, which had a negative effect. Such findings can be problematic when transposed to suicide stigma. For example, suicide behaviours by prominent public figures may reduce stigma for some people, but at the significant risk of glamorising suicide for vulnerable individuals. However, stigma reduction that focuses on promoting help-seeking, increasing awareness of prevention strategies, and challenging the ‘tainted’ status of individuals with lived experience of suicide, has the potential to have positive impacts, without increasing the risks to vulnerable people. The involvement of those with lived experience of suicide in ways that emphasise the importance of help-seeking and social support in media presentations can therefore help to achieve this and promote hope.

(Examples of the positive use of individuals with lived experience in media representations include ABC TV’s Australian Story episode, The Girl Least Likely, and Enough Rope’s Angels and Demons. See http://www.abc.net.au/austory/specials/leastlikely/default.htm and http://www.abc.net.au/tv/enoughrope/interactive/angelsanddemons/.)

The principles that underpin media guidelines are important to consider when developing suicide stigma reduction measures, and highlight the need for stringent planning and thoughtful consideration of the risks.

Issues of contention

The use of awareness campaigns and widespread discussion of suicide as a means to tackle stigma is a complex issue. There is a lack of research to show positive behaviour change following suicide awareness campaigns. This may be attributable to the relatively small number of such campaigns available for analysis. The inability to use controlled conditions also makes it difficult to show significant correlations between suicide awareness campaigns and positive behaviour change. Indeed, many of the existing evaluations tend to focus on knowledge and attitudes, rather than behaviour. The paucity of research in this area, balanced against the risks of irresponsible discussion, has the effect that public campaigns remain a contentious issue in the suicide prevention sector.

Despite this, there is no evidence that public discussion per se increases the risk of suicide. Gordon & Angus (2007) reviewed all literature published in English from 1990-2007 on the impact of suicide awareness-raising campaigns and the effects of encouraging people to talk about suicide. While they found some evidence of positive impacts on knowledge and awareness, they found no evidence of any negative impacts or risks to individuals.

It is SPA’s view that, until comprehensive campaigns – especially those focused on the Australian context – are initiated, sustained and appropriately evaluated, there will be a lack of empirical evidence of their effectiveness. However, this does not discount the fact that professional and anecdotal evidence suggests that public awareness may reduce the added burden carried by those with lived experience of suicide. It also does not discount the fact that improved public awareness also has the potential to both increase help-seeking by suicidal individuals and expand service provision and funding.
Principles for overcoming the stigma of suicide

We have shown that stigma of suicide originates from ignorance about its causes. Therefore, the starting point for reducing stigma must lie with education and awareness. However, Corrigan and O’Shaughnessy (2007) have questioned the value of education as a sole stigma reduction measure. This suggests that any campaigns designed to tackle stigma must consider the value of ‘contact’ as an awareness tool. (‘Contact’ refers to the interaction of individuals with people who are stigmatised, as a means of debunking the myths that cause the stigma, and encouraging understanding). This reinforces the view that those with lived experience of suicide may be key actors in stigma reduction.

There are numerous research studies that show the benefits of public awareness campaigns in reducing stigma and increasing help-seeking for people with mental illness (although improvements can still be made) (Rosen et al. 2000; Schulze 2009; Smith 2002; Gaebel and Baumann 2003). Principles for overcoming the stigma of suicide borrow from the experience of mental illness stigma reduction, but also contain important distinctions. Stigma reduction must not normalise, glamorise or encourage suicide; it must focus on encouraging help-seeking by removing the ‘tainted’ status of someone who is impacted by suicide, and must promote recovery. In order to be effective, suicide prevention models and initiatives must be empowerment-based, culturally relevant, and develop ways of working collaboratively with individuals and communities.

The following relate to suicide stigma and are adapted from Smith’s (2002) principles for mental illness stigma reduction:

1. Accept difference, not normalise difference.
2. Enable people to believe their own experiences, not rely on stereotypes.
3. Medicalising suicide may be partly useful, but this needs to extend beyond disease models.
4. Media should follow public opinion, not the other way around.
5. Start from what people know, not what you think they know.
6. Target the audience.
8. Involve multiple agencies.
9. Act simultaneously across several domains.

Translating principles into actions

Stigma will only be overcome through sustained, multi-faceted and multi-level measures. The stigma of suicide is so ingrained in public attitudes that one measure alone will not be sufficient, and some groups may require targeted actions. SPA advocates for the urgent investigation of social marketing, communication strategies and public health promotion measures as tools to address the stigma and lack of understanding that continue to pervade suicide.

There are some existing examples of effective campaign actions. Dumesnil and Verger (2009), for example, undertook a review of mental health and suicide public awareness campaigns. They concluded that those campaigns that applied several strategies, such as media campaigns, education programs and gatekeeper and health professional training, and which facilitated repeated exposure to the campaign, were associated with the most positive results.

Scotland’s Choose Life suicide prevention strategy uses public awareness as one of its central tenets. The country’s national Suicide. Don’t hide it. Talk about it. campaign, for instance, tackles the stigma associated with suicide, and encourages people at risk to talk to someone about feeling suicidal as a first step towards getting help. The campaign uses press, radio and online advertisements to convey its messages of promoting help-seeking and talking about suicide as a means of prevention. Evaluations of Suicide. Don’t hide it. Talk about it. have found that the campaign has been successful at increasing the awareness of suicide and help-seeking among the target audience, although the impact on behaviour has not yet been established (NHS Scotland 2008). Importantly, no campaign consumers rated the materials presented or media coverage of the campaign as anything other than beneficial (Pressdata 2010).
Another example of a successful suicide prevention and awareness campaign was undertaken in Nuremberg, Germany in 2001 and 2002, and compared with a control region (Wuerzberg). The Nuremberg campaign had four tiers and was designed to reduce suicide by increasing awareness of its causes and warning signs. Health professionals and gatekeepers both received training, community support groups were established and facilitated, and a sustained media and communications strategy was implemented. The results of the campaign saw a significant reduction in suicides and suicide attempts in correlation with increased awareness (Hegerl et al. 2006). This trend was sustained and accentuated the following year (2003), compared with the control region (Hegerl et al. 2009).

Meanwhile, the most recent social marketing-based media campaign of New Zealand’s Like Minds, Like Mine mental health anti-stigma strategy has influenced a third of its audience to change their behaviour towards those with a mental illness; indicating the benefits of social marketing campaigns in helping to reduce stigma. The biggest impact was an increase in the number of people who knew how to be supportive of a person with mental illness (Wyllie et al. 2008). The Like Minds, Like Mine strategy uses the principles of contact, education and protest to inform its campaigns (Ministry of Health 2007). ‘Protest’ refers to the active challenging of stigmatised or discriminatory attitudes or behaviours). This method of stigma reduction shows promise for suicide stigma campaigns and should be considered in the development of such campaigns in the Australian context.

MMHA’s Stepping Out of the Shadows mental health stigma reduction project has been adapted to focus on suicide prevention in some communities. The key to this initiative is its focus on tapping into the strengths, existing knowledge and resources of each targeted community. The need to be adaptive to cultural and social expectations of mental illness and suicide are considered fundamental to unravelling stigma and encouraging help-seeking.

Despite the lessons that these examples provide, a comprehensive planning and research program is required before Australia can undertake to implement any suicide awareness and stigma reduction campaign; to ensure that such a campaign is designed and delivered safely and to the highest quality.

The development of a suicide stigma reduction campaign would benefit from the following tried and tested process:

Four stages of a health communication strategy*

1. Planning and Strategy Development:
   - Set objectives and define goals
   - Research current public perceptions, issues, activities and gaps
   - Define communication objectives
   - Identify intended audience
   - Plan multiple levels of influence

2. Developing and Pre-testing Concepts, Messages, and Materials:
   - Research existing measures and messages
   - Develop message concepts (important to consider media guidelines)
   - Test concepts on intended audience
   - Develop messages and materials
   - Review messages with intended audiences
   - Plan production, distribution, promotion and evaluation of messages

3. Implementing the Program:
   - Launch strategy
   - Media engagement
   - Continuous monitoring and evaluation
   - Adjust as necessary following implementation

4. Assessing Effectiveness and Making Refinements:
   - Process and outcome evaluations
   - Adjust strategy as necessary.

*(Adapted from The Pink Book: Making Health Communication Programs Work, The National Cancer Institute n.d).
Next steps

The Senate Inquiry into Suicide in Australia (2010) resulted in the following recommendations to address the community stigma of suicide and increase awareness and help-seeking:

Recommendation 17

5.92 The Committee recommends that the Commonwealth Government fund a national suicide prevention and awareness campaign that provides information to all Australians about the risks and misconceptions of suicide, and advice on how to seek and provide help for those who may be dealing with these issues. The campaign should utilise a range of media, including television, radio, print and online, and other methods of dissemination in order to best reach the maximum possible audience. This campaign should also create links with efforts to alleviate other public health and social issues, such as mental health, homelessness and alcohol and drug use.

Recommendation 19

5.94 The Committee recommends that a national suicide prevention and awareness campaign, once developed should operate for at least 5 years, and with adequate and sustained resources. This should include the provision of additional resources, support and suicide awareness training for health care professionals (Senate of Australia 2010: xix).

A suicide stigma reduction strategy should incorporate education, contact and protest elements. It should be culturally and socially appropriate, and should be delivered through targeted and general measures. These should include gatekeeper and professional training, social marketing and media communications, political advocacy, and event-based awareness campaigns. This will require considerable resources.

SPA is encouraged by the Australian Senate’s recommendation that significant investment be contributed to a five-year suicide awareness campaign, and will be advocating for the swift allocation of funds for this recommendation. SPA will also be vigilant in advocating that any funding allocated is spent in a responsible, efficient, sustainable and effective way that poses no risk to vulnerable individuals and contributes towards preventing suicide and reducing the burden that the stigma of suicide places on individuals.

As the national advocate for suicide prevention, intervention and postvention in Australia, SPA is well positioned to lead and coordinate future stigma reduction campaigns in collaboration with partners from the suicide prevention and mental health sectors. SPA considers this of paramount importance to effectively preventing suicide and improving the lives of those with lived experience of suicide.
References and further reading


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