Research Priorities in Suicide Prevention

FINAL REPORT

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Executive summary

Background

Suicide prevention policy in Australia has had an increasing focus on building the evidence base to address this major public health concern. In recent times, the Australian Government has increased its investment in suicide prevention research. It has provided support for several initiatives in this area, including funding Suicide Prevention Australia to act as the lead agency for a $12 million national Suicide Prevention Research Fund, and funding the Centre for Mental Health at the University of Melbourne to play a national leadership role in suicide prevention research. The current project aims to assist these agencies to identify priority research areas to be addressed in suicide prevention.

Method

We conducted three studies to gauge current and future priorities in suicide prevention research. Current priorities were examined via reviews of journal articles published and grants and fellowships funded during the period 2010-2017 inclusive. Future priorities were assessed via a questionnaire of 390 stakeholders' views.

Key findings

Current priorities

During the eight-year period between 2010-2017, 424 suicide-related journal articles were published. During the same period, 36 grants and fellowships to the value of $10,580,619 were funded in the area of suicide prevention.

Type of research: The profiles of published literature and funded grants and fellowships were relatively similar in terms of the type of research they involved. In both cases, the majority of research was epidemiological, with a focus on descriptive analyses of rates.

Suicidal behaviour: The published journal articles and funded grants and fellowships tended to relate to suicide, suggesting this is the suicidal behaviour that has been given current priority over attempted suicide and suicidal thoughts.

Suicide method: Relatively few of the retrieved journal articles focused on particular suicide methods, but those that did tended to consider poisoning by drugs and hanging. None of the funded grants and fellowships appeared to be about specific suicide methods.

Target groups: Young people were the most commonly-researched target group in both the published literature and funded grants and fellowships, followed by people with mental health problems.

Settings: Certain settings took precedence in the research published in the peer-reviewed literature and funded through grants and fellowships. Workplaces, mental health service, and other health service settings received particular emphasis in journal articles, while grants and fellowships were primarily associated with research in community, school and mental health service settings.

Future priorities

Type of research: Stakeholders who completed the questionnaire emphasised the need for intervention studies (particularly studies of indicated interventions, and, to a lesser extent, studies of universal interventions). They did not discount epidemiological studies, but suggested that they should involve an increased focus on protective factors.

Suicidal behaviour: Stakeholder identified research priorities primarily highlighted the need for future research into attempted suicide (followed by research into suicide, and suicidal thoughts).

Suicide method: Stakeholders identified hanging as their highest ranked future research priority.

Target groups: Stakeholders indicated that the emphasis on young people was appropriate and should be carried through as a future priority. Their views were mixed as to the priority that should be afforded to other groups, but suggested that Indigenous people, adults, people who have attempted suicide and people with mental health problems warrant attention.

Settings: Settings identified by stakeholders as being priorities for future research included communities first and foremost, but also schools, mental health service settings, primary care settings, and emergency departments.

Implications of the findings for the national research agenda

The findings suggest that priority should be given to funding studies that evaluate interventions. Our collective understanding of what works (and what doesn't work) in suicide prevention is still insufficient, and it is crucial that we bolster this understanding if we are to move the suicide prevention field forward. It is only through examining the effectiveness – and ideally the cost-effectiveness – of interventions that our knowledge in this area will increase.

It makes sense to consider the full gamut of interventions but to perhaps give particular emphasis to indicated interventions, as suggested by stakeholders. Indicated interventions target those who are actively experiencing suicidal thoughts and/or engaging in self-harming behaviours, and there is an argument that getting these interventions right will have the greatest impact, at least in individual terms.

The findings also suggest that we should perhaps be more circumspect about the kinds of epidemiological studies that we support. A considerable amount of the current research effort has been on studies of rates of suicide among particular population groups and on factors that heighten suicide risk. As the stakeholders in our study indicated, future epidemiological studies should focus on creating new knowledge, particularly regarding protective factors. Answering questions about protective factors and the mechanisms by which they operate could make a significant contribution.

There is an argument that suicide prevention research should be broadened to include additional studies on suicide attempts, as requested by stakeholders. There is much to be learned from people who have survived suicide attempts.

The findings are perhaps less clear when it comes to priorities relating to target groups, suicide methods and settings. Existing research focuses on a variety of target groups and settings and rarely considers a single suicide method, and stakeholders had mixed views about where future efforts should be invested. Additional information is required to guide decisions in these areas. For example, decisions about the attention that should be afforded to particular target groups might be influenced by objective measures of the significance of the problem for them – e.g., group specific rates, indices of relative risk, indices of population attributable risk, and measures

of burden. Similarly, decisions about which settings to choose as priorities for suicide prevention research might be based on factors like the extent to which particular settings contribute to or mitigate suicide risk, and the extent to which interventions might be delivered through them. Likewise, the relative emphasis that might be given to studies of particular suicide methods might be determined by criteria like the proportion of suicides (or attempted suicides) that are accounted for by them, and the extent to which they might be amenable to intervention (e.g., through means restriction).

Conclusions

The recent Australian Government emphasis on supporting suicide prevention research has been welcomed by the sector. There is an acknowledgement that strengthening the evidence base could be a game-changer in terms of how we approach suicide prevention, and the key to this is ensuring that the research we do addresses the right questions. The current priority-setting exercise has helped to shed light on some of the gaps in suicide prevention research that stakeholders want to see filled. In particular, it has demonstrated that there is a relative dearth of intervention studies and studies that might help us to develop effective interventions (e.g., studies that tease out the factors that are protective against suicide and suicidal behaviour that might be promoted via appropriate interventions). Mechanisms to support research in these areas are likely to lead to significant knowledge gains.

Chapter 1: Background and methodological overview

Background

Suicide is a major public health problem in Australia. In 2016, the year for which most recent data are available, there were 2,862 suicides, 2,149 by males and 713 by females. This represents an overall rate of 11.7 per 100,000, and rates for males and females of 17.8 and 5.8 per 100,000, respectively. Worryingly, despite a slight decline in the suicide rate in 2016, the overall Australian suicide rate has been increasing over recent years; the overall, male and female rates in 2006 were 10.4, 16.0 and 4.8 per 100,000.[1]

Suicide prevention policy in Australia has had an increasing focus on building the evidence base to address this major public health concern. In recent times, the Australian Government has increased its investment in suicide prevention research. It has provided support for several initiatives in this area, including funding Suicide Prevention Australia to act as the lead agency for a $12 million national Suicide Prevention Research Fund, and funding the Centre for Mental Health at the University of Melbourne to play a national leadership role in suicide prevention research. The current project aims to assist these agencies to identify priority research areas to be addressed in suicide prevention.

The project builds on a previous project conducted by our team in 2006, which in turn drew on earlier work by Jorm and colleagues.[2-4] Our earlier project compared (then) current research efforts in suicide prevention research with stakeholder-identified priorities.[5] We identified suicide-related journal articles published and grants funded in Australia in 1999-2006 and classified them according to a pre-determined framework. We asked 231 stakeholders with an interest in suicide prevention where they thought future priorities should lie, using a questionnaire which categorised their responses according to the same framework. The take-home message from this work was that much of the existing effort had focused on the epidemiology of suicide and suicidal behaviour whereas stakeholders felt that future emphasis should be on intervention studies. At the time, we recommended that future research focus on conducting studies of interventions that would allow evidence to amass about what works (and what does not work) in suicide prevention.

Identifying current and future priorities in suicide prevention research

The current project largely replicated our original one, but augmented it in such a way as to be maximally useful in the current Australian suicide prevention context. We conducted three studies to gauge current and future priorities in suicide prevention research. Current priorities were examined via reviews of journal articles published and grants and fellowships funded during the period 2010-2017 inclusive. Future priorities were assessed via a questionnaire of stakeholders' views. Table 1 summarises the method employed in each of the three studies, and additional detail is provided in Chapters 2-4.

Table 1: Summary of studies

CURRENT PRIORITIES IN SUICIDE PREVENTION RESEARCH	FUTURE PRIORITIES IN SUICIDE PREVENTION RESEARCH
Study 1: Review of published literature Analysis of extent and nature of current research, as assessed by examination of abstracts of peer-reviewed journal articles on suicide prevention research published during the period 2010-2017 inclusive.	**Study 3: Web-based questionnaire** Analysis of stakeholders' views on future priorities, elicited via a web-based questionnaire. Stakeholders were selected on the basis of their membership of 15 groups with a known interest in suicide prevention research.
Study 2: Review of funded grants Analysis of extent and nature of current research, as assessed by examination of summaries of grants and fellowships funded by key granting bodies during the period 2010-2017 inclusive.	

Defining 'suicide prevention research'

We defined 'suicide prevention research' relatively broadly, drawing on the definition of mental health research used by Jorm and colleagues in their earlier project[2-4] and on the definition of suicide prevention research that we used in our own previous study.[5] Specifically, we defined 'suicide prevention research' as

> *'... [involving] activities which collect new data or carry out some novel analysis of existing data, and which pertain to suicide prevention but may not necessarily involve evaluation of suicide prevention initiatives.'*

For the purposes of the current project, research relating to euthanasia was excluded from the above definition.

A framework for examining current and future priorities

The reviews of published literature and funded grants/fellowships and the web-based questionnaire were conducted within a comprehensive framework which enabled current and future priorities to be examined in a systematic manner. This framework was largely identical to the one utilised in our earlier study, and included only very minor modifications to update the terminology of some of the item categories.[5] The framework permitted different elements of suicide prevention research to be considered within various classifications, namely research type, suicidal behaviour, suicide method, target group and setting. The sub-categories within the framework are summarised in Table 2.

Table 2: Framework for examining current and future priorities in suicide prevention research

Research type	
a. Assessment studies • Assessment/classification of suicide risk (including development/validation of risk assessment tools) • Assessment studies – Other b. Epidemiological studies • Rates (including comparisons of rates) • Risk factors • Protective factors • Epidemiological studies – Other c. Intervention studies • General intervention issues and approaches • Practice guidelines • Efficacy of universal interventions • Efficacy of selective interventions • Efficacy of indicated interventions • Intervention studies - Other	d. Evaluation of policies/programs/services • Policy evaluation • Program evaluation • Services evaluation • Evaluation of policies/programs/services - Other e. Biological research • Neurobiology (including brain anatomy and physiology) • Genetics • Biological research – Other f. Social science • Sociology • History • Literature or the arts • Media studies (incl. new media and internet) • Social science – Other g. Other h. Not specified / unknown
Suicidal behaviour	
a. Suicide b. Attempted suicide c. Suicidal thoughts	d. Other suicidal behaviour e. Not specified / unknown
Suicide method	
a. Poisoning by drugs b. Poisoning by other (incl. poisoning by other gases and vapours) c. Hanging (incl. strangulation and suffocation) d. Firearms (incl. explosives) e. Drowning	f. Jumping from a high place g. Jumping or lying before a moving object h. Other i. Not specified / unknown
Target group	
a. Young people (aged 24 or less) b. Adults (aged 25-64) c. Older people (aged 65 or more) d. Indigenous people e. People from culturally and linguistically diverse backgrounds f. People in rural and remote areas g. People bereaved by suicide h. People who are gay, lesbian, bisexual, transgender, intersex i. People with mental health problems	j. People with physical health problems k. People with substance use problems l. People who have attempted suicide m. Offenders n. Men o. Women p. Current or ex-serving military personnel q. Other r. Not specified / unknown
Setting	
a. Communities b. Schools c. Tertiary institutions d. Prisons e. Workplaces f. Primary care settings (e.g. general practice)	g. Emergency departments h. Mental health service settings i. Other health service settings j. Other k. Not specified / unknown

These classifications and the categories within them are largely self-explanatory, with a few possible exceptions. Specifically, it is worth commenting on Research type. The identified types were deliberately designed to be as inclusive as possible, and to recognise that suicide prevention research occurs not only in medical and psychiatric domains, but also in the social sciences. It is also worth providing definitions for universal, selective and indicated interventions, referred to under intervention studies. Universal interventions target whole populations, with the aim of favourably shifting risk and protective factors across the whole population. Selective interventions target population subgroups with particular risk factors for suicide who are not yet exhibiting suicidal thoughts or behaviours. Indicated interventions are designed for people who are already beginning to exhibit suicidal thoughts or behaviours.

The application of the framework can be explained by the example of target group. Each journal abstract and grant summary was coded in terms of the target group that was the focus of the

research, in order to determine whether particular target groups had been given greater or lesser priority in the past eight years. Similarly, questionnaire respondents were asked to make ratings as to the target group(s) which should be given highest priority. The framework therefore enabled comparisons to be made between the status quo, or current priorities, and stakeholder-identified future priorities.

Structure of the current report

The remainder of this report describes the project in detail. As noted above, Chapters 2-4 provide methodological information about each of the three studies. These chapters also highlight the key findings from each of the three studies. Chapter 5 synthesises these findings, comparing and contrasting current research priorities in suicide prevention with those which stakeholders view as important for future work. Based on these findings, Chapter 5 also makes recommendations for the national research agenda.

Chapter 2: Review of published literature (Study 1)

Method

As noted in Chapter 1, the review of published literature analysed the extent and nature of current research by examining the abstracts of peer-reviewed journal articles on suicide prevention research published during the period 2010 to July 2017 inclusive. The abstract identification and retrieval process is described in more detail below, as is the way in which the abstracts were coded. The approach to data analysis is also described.

Abstract identification and management

We restricted the review to literature published in peer-reviewed journals, on the grounds that this was the most systematic way to identify current research. Time and resources did not permit a comprehensive search of other sources, such as reports in the 'grey' literature or student theses. Letters, reports, conference abstracts, book chapters, news items, magazine articles and newsletters were also beyond the scope of the review. The decision to focus on peer-reviewed journal articles is consistent with the approach taken by Jorm and colleagues in their earlier study[2-4] and with that of our own previous project,[5] and affords some check on the quality of the research included in the review.

We searched three international academic databases (Medline; PsycInfo and CINAHL) for peer-reviewed articles published during the period from January 2010 to July 2017. We used the following search terms in this process: suicid* OR self harm OR suicid* attempt* AND Australia.

For consistency with the definition of suicide prevention research provided in Chapter 1, we excluded articles from the review if they pertained to euthanasia (or assisted suicide). Articles were also excluded if they did not include a full abstract; did not involve primary research, a systematic or narrative review or an evidence-based commentary; and/or did not have a first author with an Australian address, or reported research not conducted in Australia.

We entered all abstracts into an Endnote database.

Abstract classification

We initially categorised abstracts by:

- Publication focus (suicide primary focus, suicide secondary focus, other focus, not specified / unknown);
- Year of publication;
- Publication type (primary research, review, evidence-based commentary, not specified / unknown);
- Type of data (qualitative, quantitative, other, not specified / unknown); and
- Research design (descriptive, analytical, other, not specified /unknown).

These categories are self-explanatory, with the possible exception of Publication focus and Research design. Publication focus is perhaps best explained by example. An abstract reporting

on an epidemiological study of the rates of suicide among young people would have been classified as having suicide or suicidal behaviour as its primary focus. By contrast, an abstract pertaining to an intervention study of cancer among older people in which suicidality was listed as one of many outcome variables would have been classified as having suicide or suicidal behaviour as its secondary focus.

Research design was categorised according to definitions provided by Hennekens and Buring.[6] Descriptive studies were defined as those which profiled characteristics of suicide or suicidal behaviour in relation to particular individuals or groups, with no point of comparison. By contrast, analytical studies were defined as those which explicitly made comparisons between different groups in terms of risk and/or protective factors (i.e., exposure variables) and suicide or suicidal behaviour (i.e., outcome variables).

Following the initial categorisation of abstracts, we undertook further categorisation according to the framework outlined in Chapter 1. As noted, this framework enabled each abstract to be categorised according to the following classifications:

- Research type (assessment studies; epidemiological studies; intervention studies; evaluation of policies/programs/services; biological research; social science studies; other; not specified / unknown);

- Suicidal behaviour (suicide; attempted suicide; suicidal ideation; other; not specified / unknown);

- Suicide method (poisoning by drugs; poisoning by other; hanging; firearms; drowning; jumping from a high place; jumping or lying before a moving object; other; not specified / unknown);

- Target group (young people; adults; older people; Indigenous people; people from culturally and linguistically diverse backgrounds; people in rural and remote areas; people bereaved by suicide; people who are gay, lesbian, bisexual, transgender or intersex; people with mental health problems; people with physical health problems; people with substance use problems; people who have attempted suicide; offenders; men; women; current or ex-serving military personnel; other; not specified / unknown); and

- Setting (communities; schools; tertiary institutions; prisons; workplaces; primary care settings; emergency departments; mental health service settings; other health service settings; other; not specified / unknown).

In most cases, a single category was selected within each classification and coded as 1 (with the alternative, non-endorsed categories being coded as 0). For example, most studies about older people did not involve any other target group, so these abstracts received a score of 1 for older people and 0 for all other target groups. In some cases, however, an abstract covered more than one category within a given classification. To avoid double-counting, the alternatives were weighted so that they summed to 1. Continuing with the example of target groups, if an abstract described a study dealing with rural youth, young people and people in rural and remote areas were both given a weight of 0.50. Similarly, if an abstract described a study focusing on people with co-morbid mental health problems and substance use problems who had attempted suicide, all three relevant target group categories were given weights of 0.33.

Each abstract was examined and classified according to the above categories by a single team member (MF or KK) in consultation with the team leader (JP) wherever necessary.

To ensure consistency in coding, 14 abstracts were independently coded by two team members (MF and KK). Any discrepancies in the coding of abstracts between the coders were resolved by way of reviewing the code diary and clarifying and refining variable definitions. There was good inter-rater reliability.

Data management and analysis

We entered data on each abstract into a purpose-designed Excel database and subsequently imported it into SPSS for analysis. Simple weighted frequencies and percentages were calculated for each category.

Results

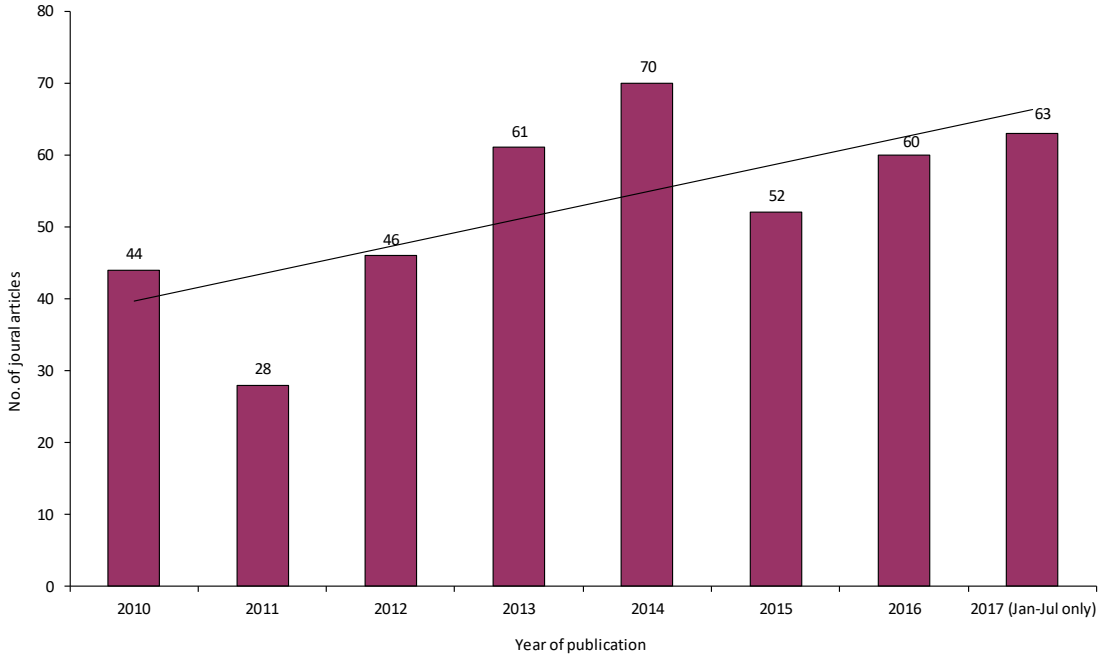
Overview

In total, we retrieved and reviewed 555 abstracts. We excluded 131 (24%) of these because their primary focus was not suicidal behaviour, and/or they were opinion papers or service descriptions. This left us with 424 in-scope abstracts (76%).

Year of publication

Information on the year of publication was available for all 424 abstracts (see Figure 1). The number of relevant journal articles produced each year ranged from 28 to 70, with the greatest number being published in 2014. The articles published in 2017 are under-represented as the cut-off month for that year was July. Notwithstanding this, the trendline indicates a steady growth in suicide-related journal articles over the past eight years.

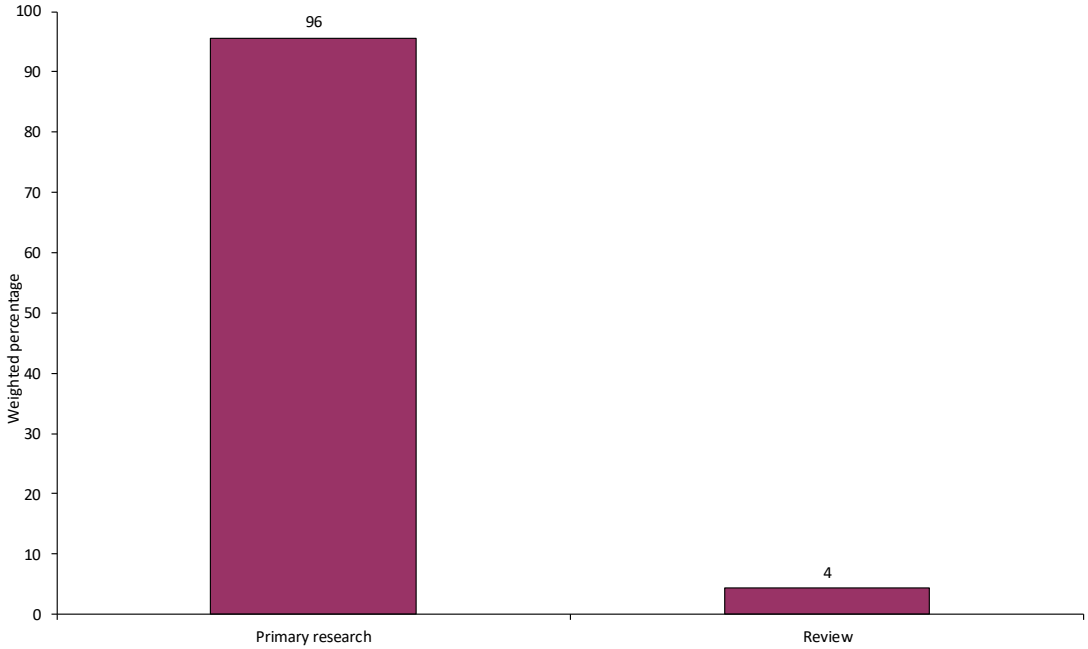
Figure 1: Journal articles for which suicide or suicidal behaviour was the primary focus, by year of publication (n=424)



Publication type

Publication type was determined for all 424 journal articles. Figure 2 profiles the abstracts by publication type. The majority (96%) of journal articles constituted primary research. The remaining 4% were reviews.

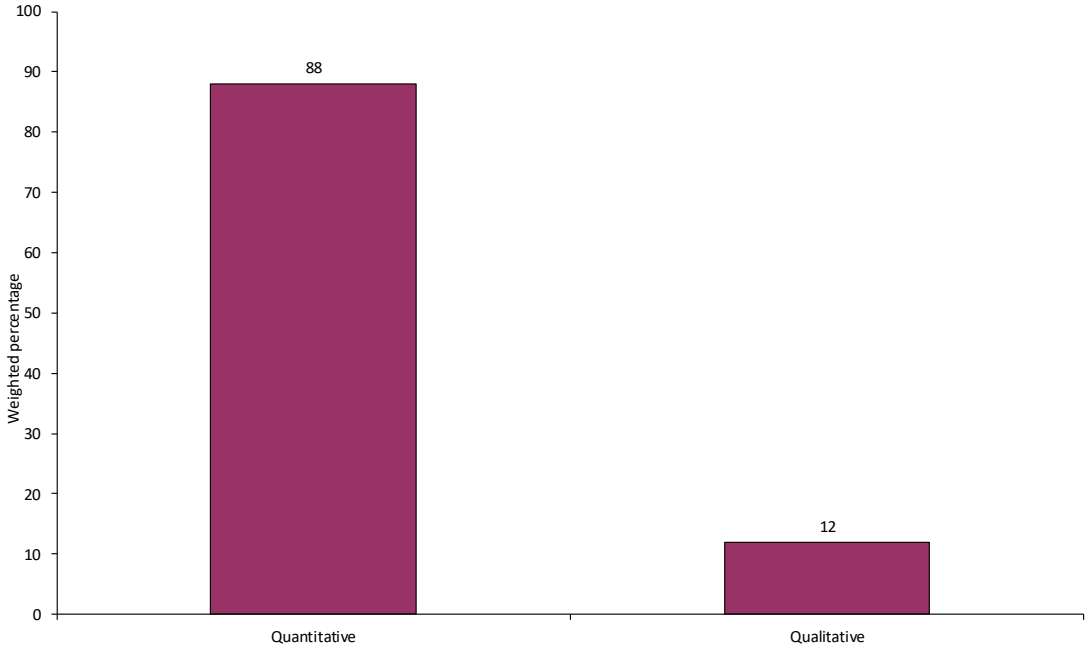
Figure 2: Journal articles for which suicide or suicidal behaviour is the primary focus, by publication type (n=424)



Type of data

The type of data reported in the given research was ascertained for 413 journal articles, based on their abstracts. Figure 3 summarises the broad type of data reported in each of these. The majority (88%) reported on quantitative data, and only 12% described qualitative data.

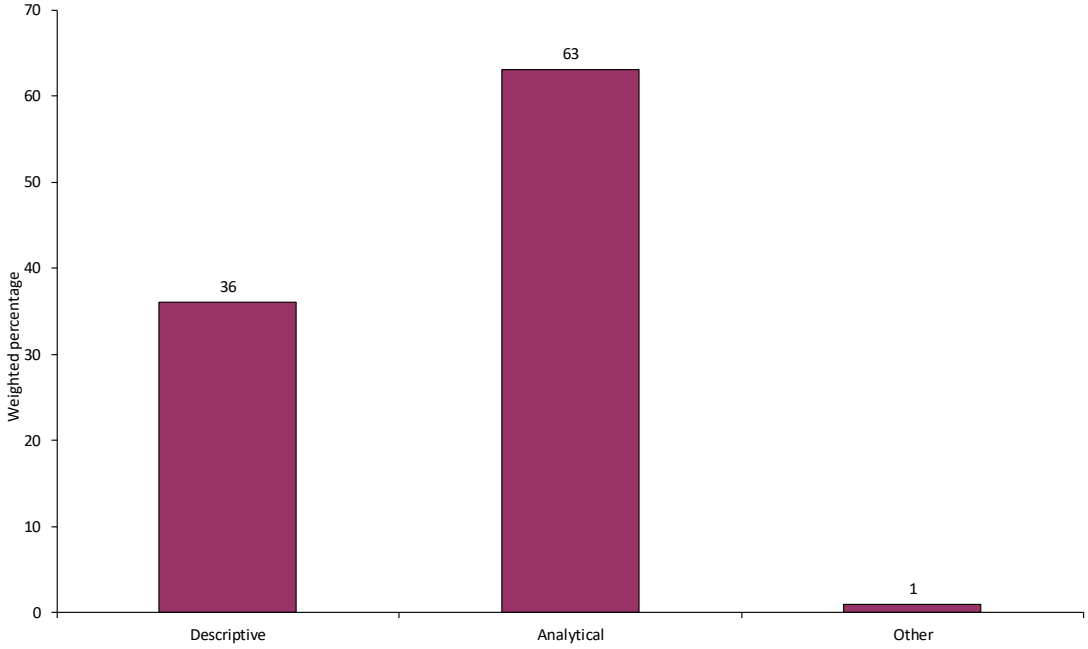
Figure 3: Journal articles for which suicide or suicidal behaviour was the primary focus, by type of data (n=413)



Research design

Information on research design was available for 420 journal articles. As Figure 4 shows, 63% of these employed an analytical design where they explicitly made comparisons between different groups in terms of suicidal outcomes or risk and protective factors. The majority of the remainder (36%) used a descriptive approach which involved no comparisons.

Figure 4: Journal articles for which suicide or suicidal behaviour was the primary focus (n=420), by research design



Research type

Research type could be discerned for all 424 journal articles. Figure 5 profiles these journal articles by high level categories and Figure 6 by more detailed, lower level categories.

Figure 5 shows that by far the most common research type represented in the journal articles was epidemiological research. These types of studies accounted for 60% of all journal articles. Intervention studies were the next most common research type at 14%, followed by assessment and evaluation studies which were the focus of 7% and 6% of journal articles respectively.

Figure 5: Journal articles for which suicide or suicidal behaviour was the primary focus, by research type (high level categories; n=424)

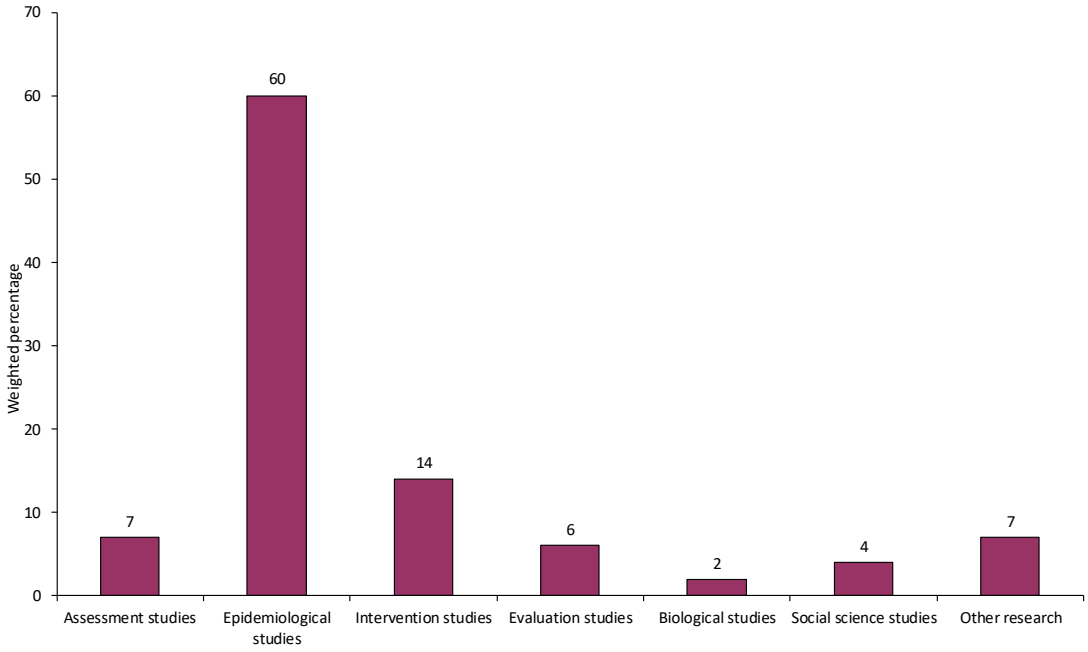
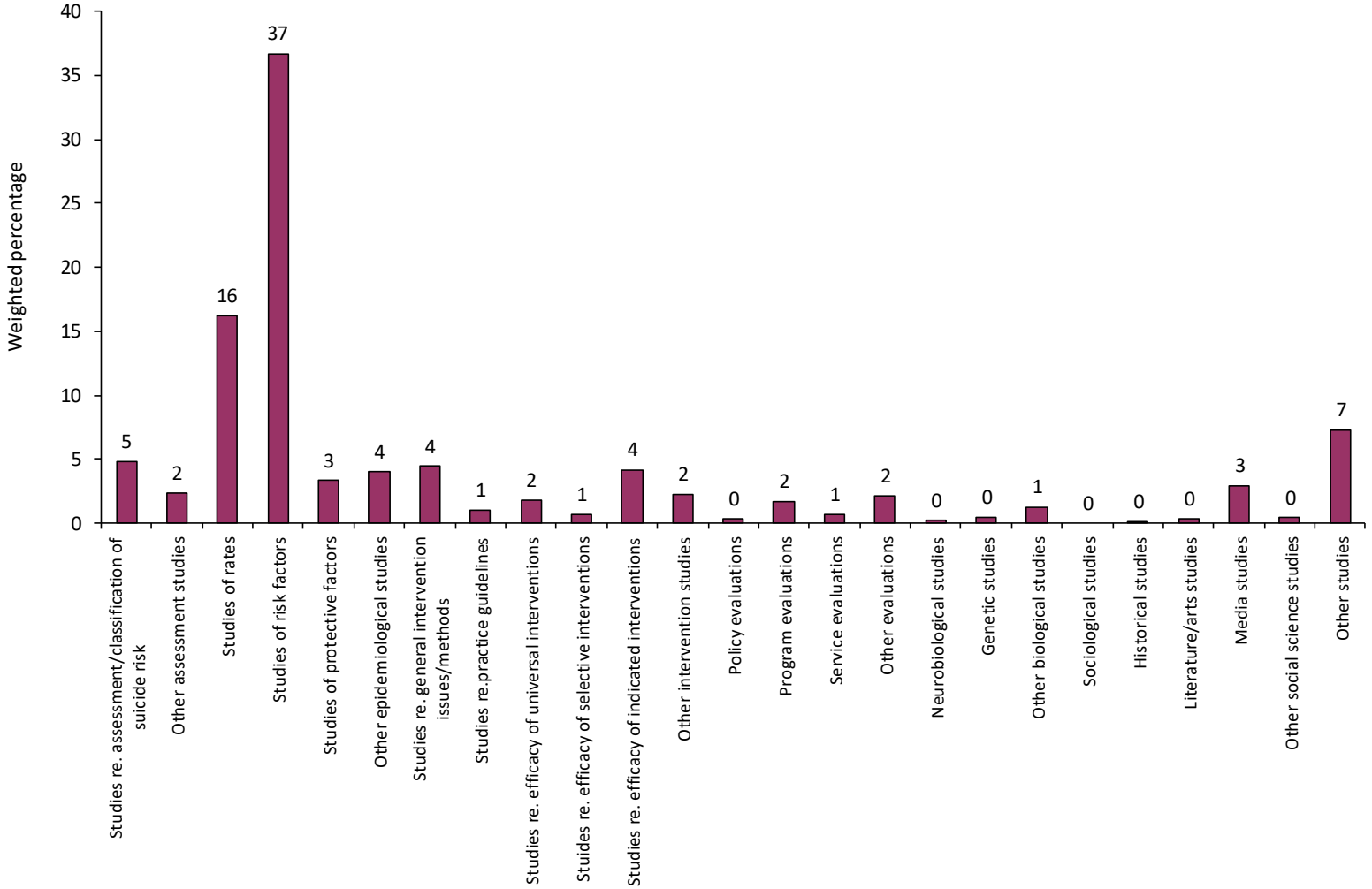


Figure 6 shows that epidemiological studies of risk factors were the most common, accounting for 37% of journal articles. These were followed by epidemiological studies of rates of suicide, which made up a further 16%.

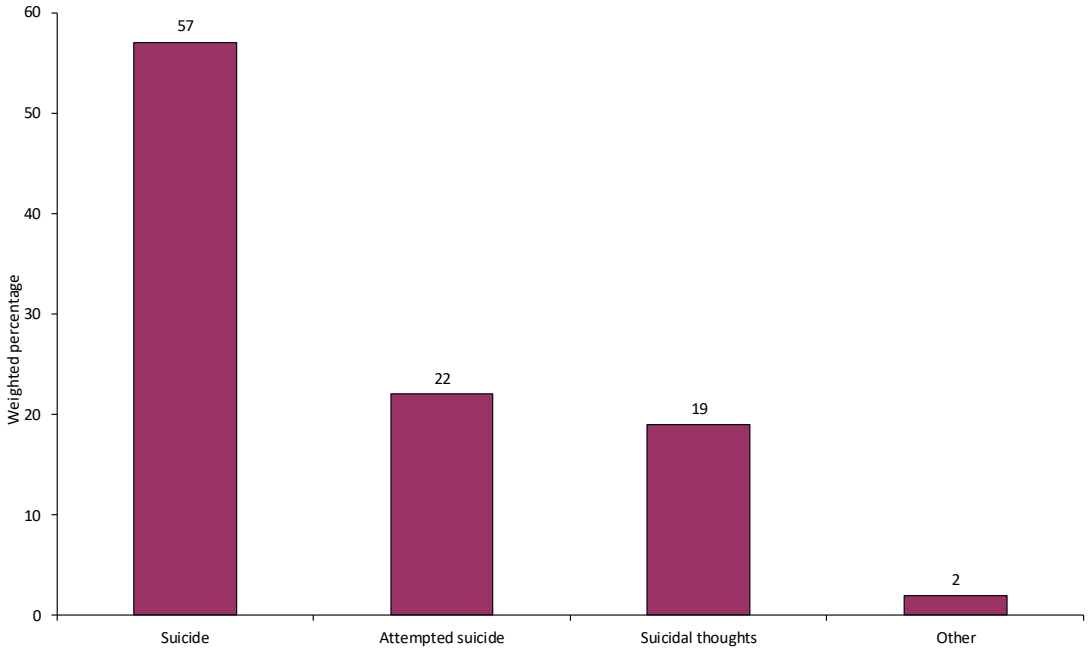
Figure 6: Journal articles for which suicide or suicidal behaviour was the primary focus, by research type (lower level categories; n=424)



Suicidal behaviour

The type of suicidal behaviour being investigated could be determined for 418 of the journal articles. Figure 7 shows that 57% of the journal articles focused on suicide, 22% focused on attempted suicide and 19% focused on suicidal thoughts.

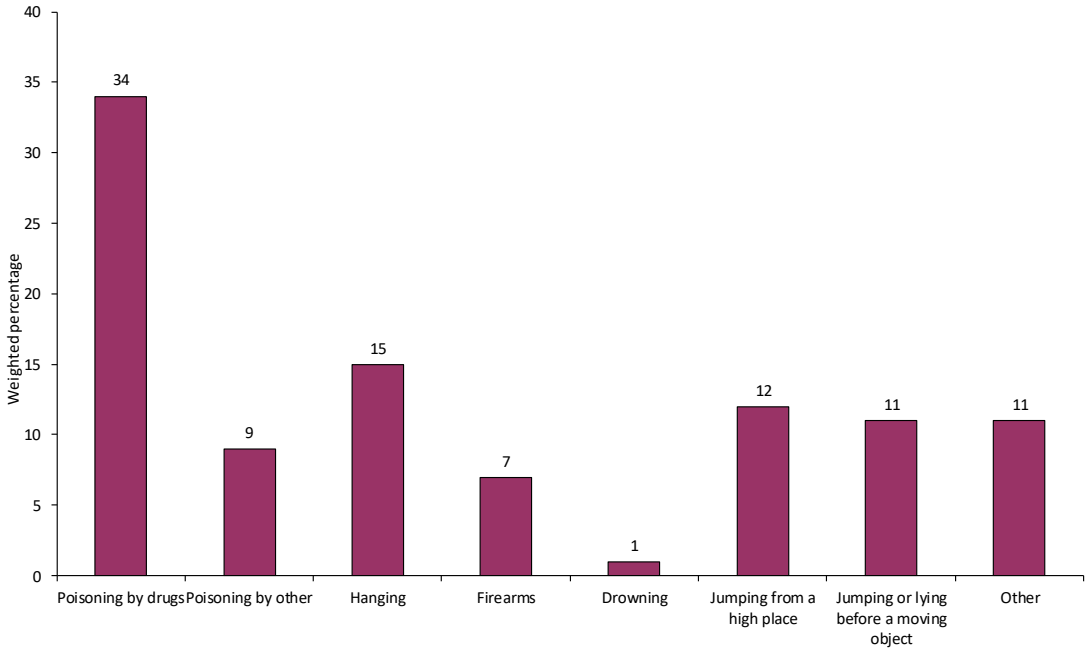
Figure 7: Journal articles for which suicide or suicidal behaviour was the primary focus, by suicidal behaviour (n=418)



Suicide method

Only 56 of the 424 journal articles were concerned with a particular suicide method. Figure 8 presents the suicide method of interest across these 56 abstracts. Poisoning by drugs was the most common method, represented in 34% of journal articles. This was followed by hanging (15%) and jumping from high places (12%).

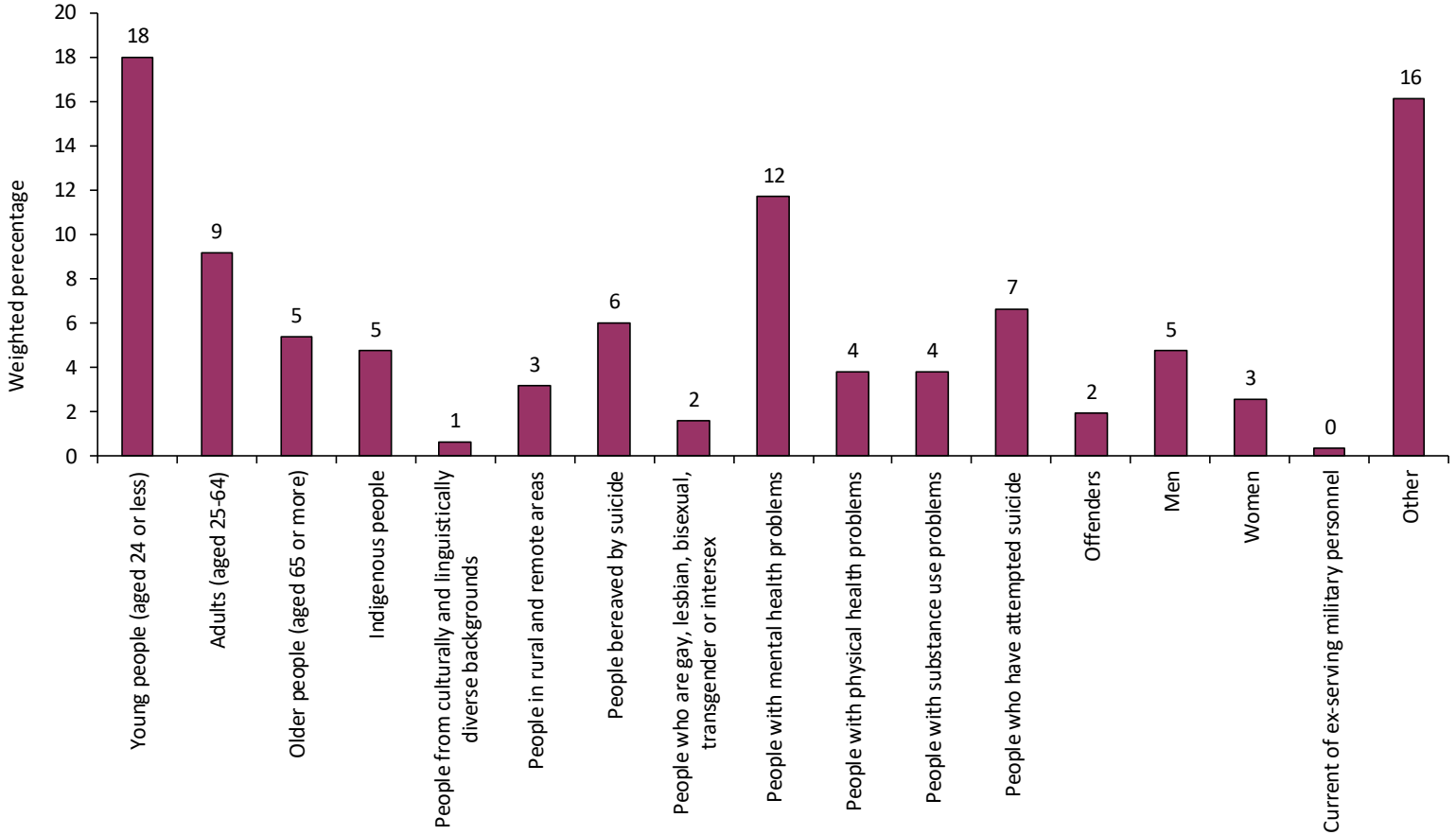
Figure 8: Journal articles for which suicide or suicidal behaviour was the primary focus, by suicide method (n=56)



Target group

A target group was described in 317 journal articles (see Figure 9). Young people aged 24 years and under received the most research attention, with 18% of journal articles focusing on them. Next were people with mental health problems (12%). The 'other' target group category accounted for 16%, suggesting that there was growing research interest in health professionals, physicians and refugees.

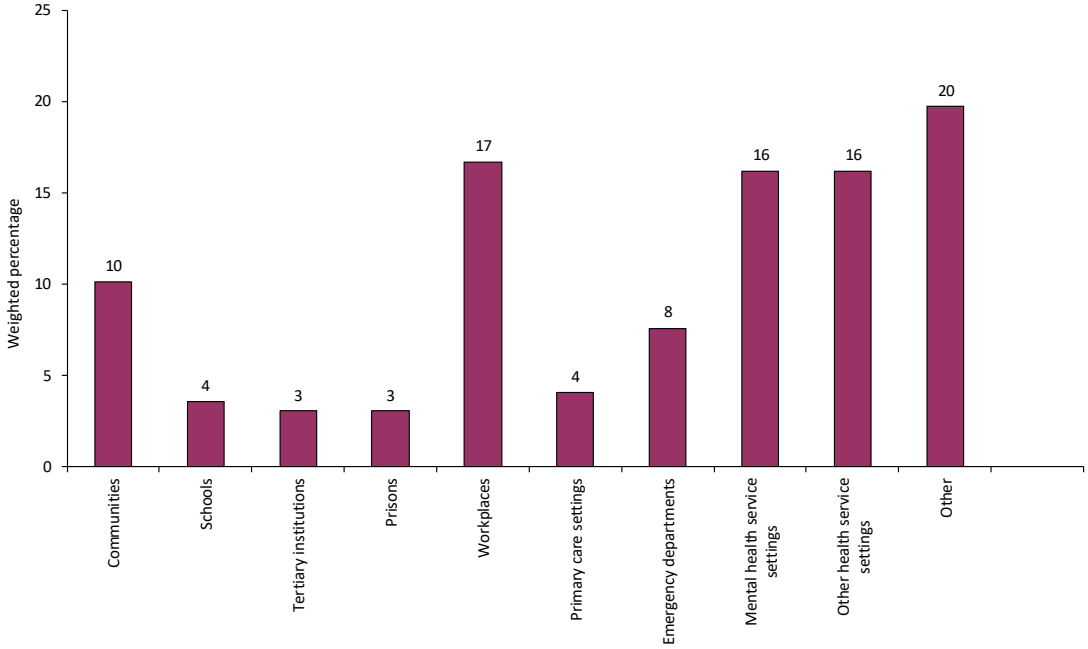
Figure 9: Journal articles for which suicide or suicidal behaviour was the primary focus, by target group (n=317)



Setting

The research setting could be identified in 198 of the journal articles. Figure 10 shows that 17% of these involved research in workplaces, 16% in mental health service settings, and 16% in other health service settings (e.g., aged care facilities, treatment centres). Settings in the 'other' category made up 20%. This category captured a variety of settings, including online networks and suicide hotspots.

Figure 10: Journal articles for which suicide or suicidal behaviour was the primary focus, by setting (n=198)



Chapter 3: Review of funded grants and fellowships (Study 2)

Method

As noted in Chapter 1, the review of funded grants and fellowships analysed the extent and nature of current research by examining grants and fellowships provided for suicide prevention research during the period 2010-2017 inclusive. The grant identification and retrieval process is described in more detail below, as is the way in which the grants and fellowships were coded. The approach to data analysis is also described.

Identification of information about funded grants and fellowships

We identified grants and fellowships funded by the National Health and Medical Research Council (NHMRC), Australian Rotary Health (ARH), the Australian Research Council (ARC), and the Society for Mental Health Research (SMHR).

We retrieved publicly available summary information on grants and fellowships awarded by these agencies from their respective website repositories on 11 September 2017. The amount and format of funding information available varied slightly by organisation:

- The NHMRC, ARH and ARC provided Excel spreadsheets and summary reports detailing all grants and fellowships awarded between 2010 and 2017 inclusive.

- The SMHR provided summary information on early career research fellowships awarded during the 2015 and 2016 funding rounds, the earlier year being the year in which this type of funding first commenced.

All grants and fellowships were examined by one member of our team (LR) who identified all those that appeared to relate to suicide.

Table 3 provides a summary of the information available on each of the grants and fellowships, broken down by funding body. Note that some funding schemes offered by a particular organisation were not covered by the full time period indicated, either because the information was not available for each year or because they were introduced (or discontinued) during the period.

Table 3: Information available on suicide prevention research grants and fellowships, by funding body

	NHMRC	ARH	ARC	SMHR
Funding years	2010-2017*	2010-2017*	2010-2017*	2015-2016
Grant type	☑	☑	☑	☑
Chief investigator	☑	☑	☑	☑
Project/fellowship title	☑	☑	☑	☑
Administering institution	☑	☑	☑	☑
State/territory	☑	☑	☑	☑
Start year	☑	☑	☑	☑
Duration	☑	☑	☑	☑
Amount of funding per year	☑	☑	☑	☑
Total funding	☑	☑	☑	☑
Abstract/summary	☑	☑	☑	☑

* Funding in 2017 only includes grants and fellowships awarded prior to 11 September.

Coding the grants and fellowships

Grants and fellowships were initially categorised by:

- Year of initial funding;
- Funding (amount per year and total);
- Grant/fellowship focus (suicide primary focus, suicide secondary focus, other focus, not specified / unknown).

We included all grants and fellowships with an official start (or funding commencement) year in the 2010-2017 period, provided the primary focus of funded activities was on suicide and the research was conducted in Australia.

Beyond this, we classified all grants and fellowships in the same way as the journal articles described in Chapter 2, using the framework outlined in Chapter 1. This enabled each grant or fellowship to be categorised according to the following classifications:

- Research type (assessment studies; epidemiological studies; intervention studies; evaluation of policies/programs/services; biological research; social science studies; other; not specified / unknown);
- Suicidal behaviour (suicide; attempted suicide; suicidal thoughts; other; not specified / unknown);
- Suicide method (poisoning by drugs; poisoning by other; hanging; firearms; drowning; jumping from a high place; jumping or lying before a moving object; other; not specified / unknown);
- Target group (young people; adults; older people; Indigenous people; people from culturally and linguistically diverse backgrounds; people in rural and remote areas; people bereaved by suicide; people who are gay, lesbian, bisexual, transgender or intersex; people with mental health problems; people with physical health problems; people with substance use problems; people who have attempted suicide; offenders; men; women; current or ex-serving military personnel; other; not specified / unknown); and

- Setting (communities; schools; tertiary institutions; prisons; workplaces; primary care settings; emergency departments; mental health service settings; other health service settings; other; not specified / unknown).

In the case of most grants and fellowships, a single category was selected within each classification and coded as 1 (with the alternative, non-endorsed categories being coded as 0). In some cases, however, a grant or fellowship covered more than one category within a given classification. To avoid double-counting, the alternatives were weighted so that they summed to 1.

Each grant or fellowship was examined and classified according to the above categories by one member of our team (LR), in consultation with another (KK) and the team leader (JP) wherever necessary.

Data management and analysis

Data provided by the funding bodies and generated during the course of coding the grants and fellowships were entered into an Excel spreadsheet. Simple weighted frequencies and percentages were calculated for each category.

Results

Overview

In total, 21 grants and 15 fellowships were provided for research into suicide or suicidal behaviour between 2010 and 2017. Table 4 provides a breakdown of these grants and fellowships by year of initial funding and funding body, and a full listing is provided at Appendix B.

Table 4: Number of grants and fellowships provided for research into suicide or suicidal behaviour, by year of initial funding and funding body

	NHMRC	ARH	ARC	SMHR	Total
2010	1	1	1	0	3
2011	0	0	0	0	0
2012	0	1	1	0	2
2013	2	1	0	0	3
2014	6	3	1	0	10
2015	2	3	1	3	9
2016	1	1	1	1	4
2017*	2	3	0	0	5
Total	14	13	5	4	36

* Funding in 2017 only includes grants and fellowships awarded prior to 11 September.

The total funding for these grants during the observation period was $10,580,619.[a] Table 5 shows the relative distribution of this funding by year and funding body. Note that the funding

[a] It should be noted that some of the later projects provided funding for the years 2018-2019, but this additional funding is not included here. Moreover, the total does not include grants from any funding rounds that were announced after 11 September 2017, the date when data were retrieved for this study.

for projects of longer than one year duration is split across funding years, according to the way in which it was allocated by the funding body.

The total funding for suicide prevention research has increased significantly over the past eight years, with a peak in 2015. The NHMRC has continued to be the most significant funder of suicide prevention research, which is not surprising given its relative level of resources and its health and medical remit. Its investment has increased substantially over the study period, and particularly in the wake of the 2013 Targeted Call for Research into Suicide Prevention among Aboriginal and Torres Strait Islander peoples.

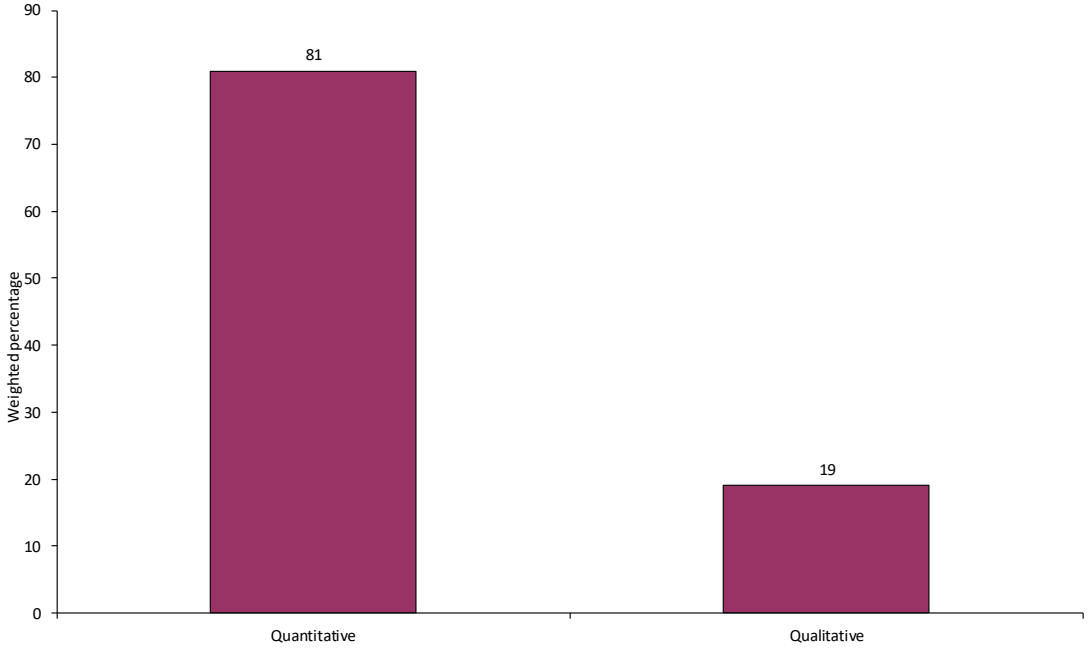
Table 5: Value of grants and fellowships provided for research into suicide or suicidal behaviour, by year and funding body

	NHMRC	ARH	ARC	SMHR	Total
2010	$52,860	$29,000	$15,000	$0	$96,860
2011	$52,860	$29,000	$30,000	$0	$111,860
2012	$52,860	$99,000	$87,470	$0	$239,330
2013	$222,297	$99,000	$93,944	$0	$415,241
2014	$939,316	$273,000	$266,586	$0	$1,478,902
2015	$2,048,106	$413,000	$240,566	$300,000	$3,001,672
2016	$2,083,987	$427,500	$295,100	$20,000	$2,826,587
2017	$1,791,736	$422,500	$195,931	$0	$2,410,167
Total	$7,244,022	$1,792,000	$1,224,597	$320,000	$10,580,619

Type of data

The type of data collected via the activities funded could be determined for 21 grants and fellowships. Figure 11 summarises these data types and shows that 81% involved quantitative data collection and 19% qualitative data collection.

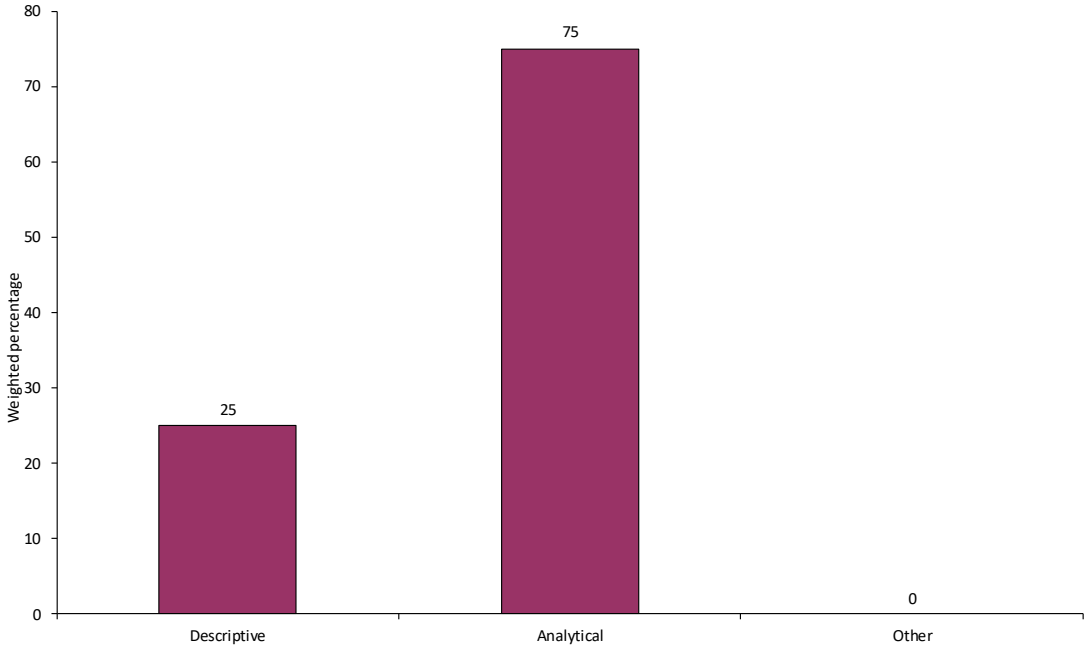
Figure 11: Grants and fellowships provided for suicide prevention research, by type of data (n=21)



Research design

Information on research design was available for 20 grants and fellowships. As Figure 12 shows, 75% employed analytical designs, making comparisons across groups or time. The remaining 25% used descriptive designs, with no point of comparison.

Figure 12: Grants and fellowships provided for suicide prevention research, by research design (n=20)



Research type

Research type could be ascertained for 32 grants. Figure 13 profiles these grants by the high level categories of research type, and Figure 14 by the lower level categories.

Figure 13 shows that 34% of grants and fellowships provided funding for epidemiological studies, 30% for intervention studies, and 17% for social science studies. Evaluation studies (13%) and assessment studies (6%) were funded to a lesser extent. No funding was awarded to biological research.

Figure 13: Grants and fellowships provided for suicide prevention research, by research type (high level categories; n=32)

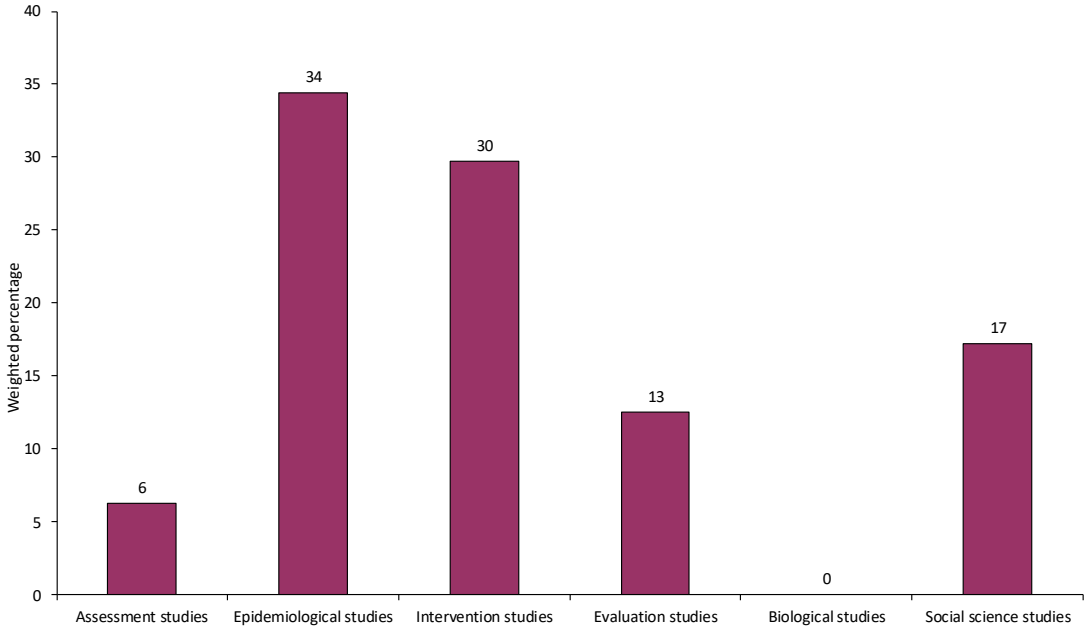
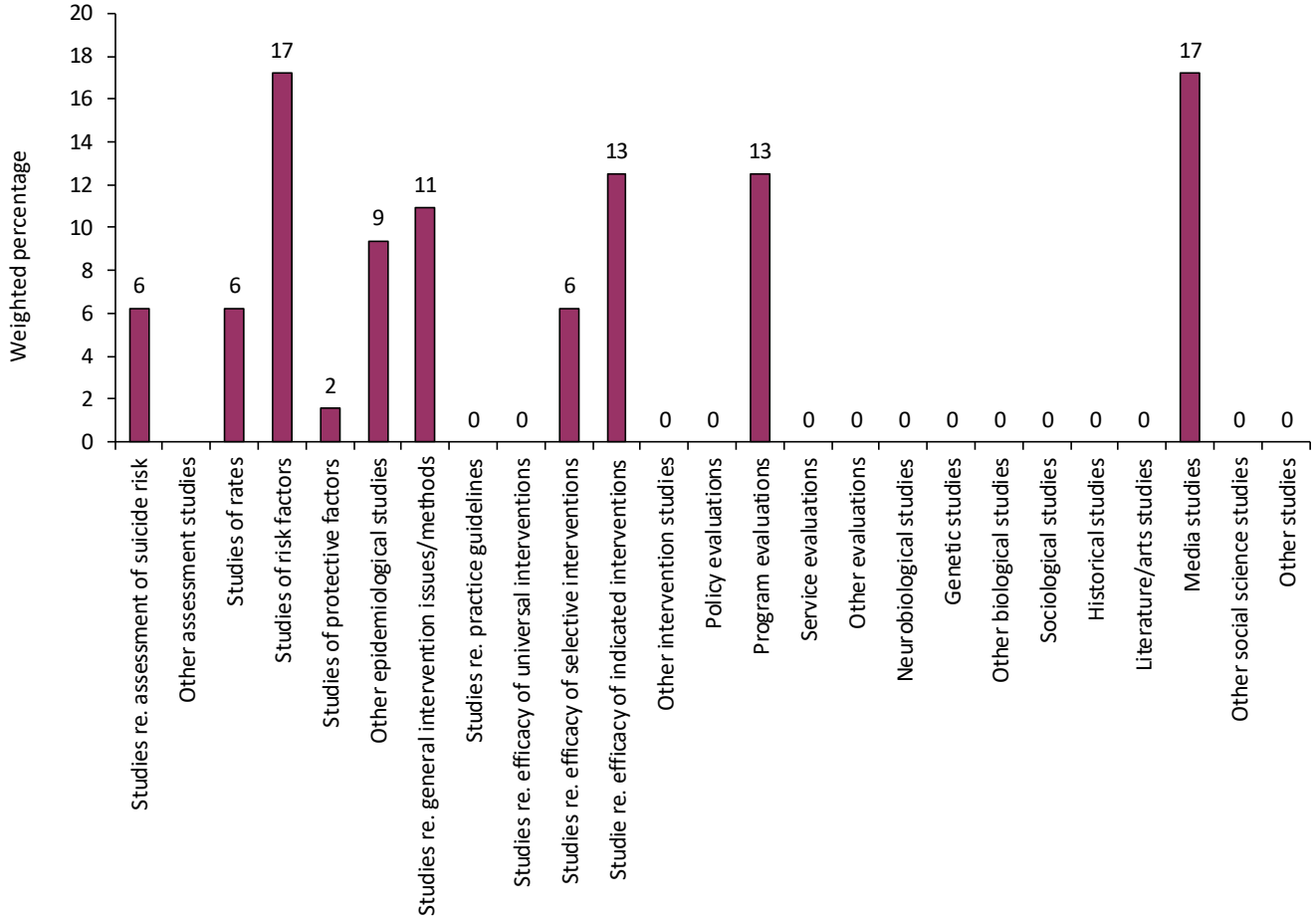


Figure 14 shows lower level research types which indicate that 17% of funding was devoted to both studies of risk factors and media studies (including studies of new media and the internet). Studies of the efficacy of indicated interventions and program evaluation studies each accounted for 13% of funding. Studies of general intervention issues/methods attracted 11% of grant funding, and other epidemiological studies 9%. A number of research types were awarded no funding.

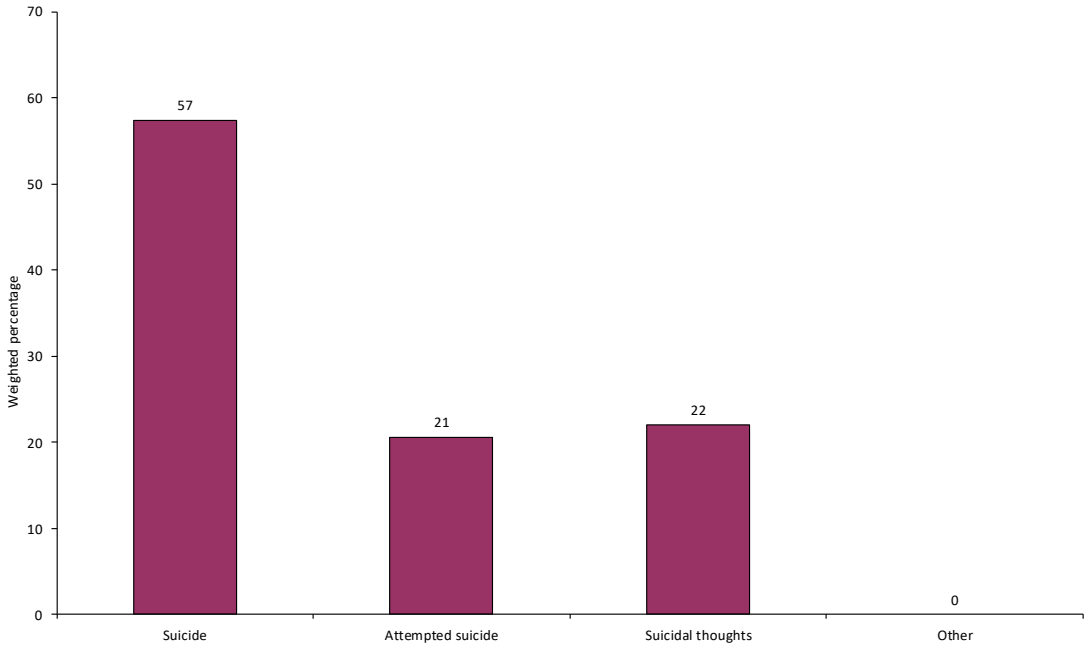
Figure 14: Grants and fellowships provided for suicide prevention research, by research type (lower level categories; n=32)



Suicidal behaviour

The suicidal behaviour of interest could be ascertained in 34 of funded grants and fellowships. Figure 15 profiles these and indicates that 57% of these grants and fellowships focussed on suicide, 22% on suicidal thoughts, and 21% on attempted suicide.

Figure 15: Grants and fellowships provided for suicide prevention research, by suicidal behaviour (n=34)



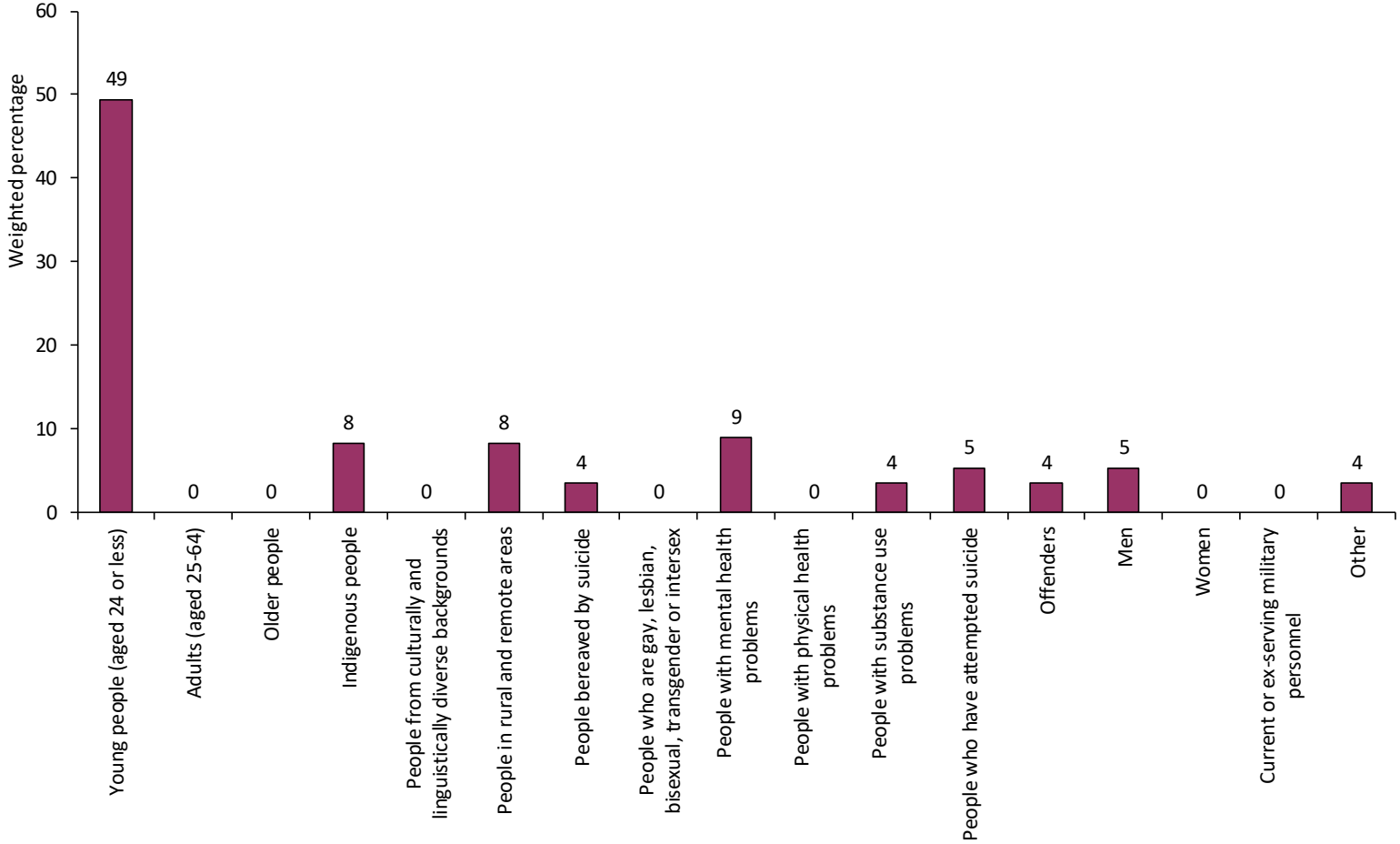
Suicide method

Insufficient information was available on the grants and fellowships to determine whether they funded activities relating to individual suicide methods. Having said this, most appeared to address suicide and/or suicidal behaviour generally, rather than focusing on specific methods.

Target group

In the case of 28 grants and fellowships, it was possible to make a judgement about whether they related to a particular target group. Figure 16 shows the target group of interest in these 28 grants and fellowships. The greatest emphasis appears to have been given to young people (49%), followed by people with mental health problems (9%), Indigenous people (8%), people in rural and remote areas (8%), men (5%), and those who have attempted suicide (5%). Relatively less attention has been directed towards people bereaved by suicide, people with substance use problems, and offenders. No grants or fellowships could be identified as having funded research targeting adults, older people, people from culturally and linguistically diverse backgrounds, people who are gay, lesbian, bisexual, transgender or intersex, people with physical health problems, women, and current or ex-serving military personnel.

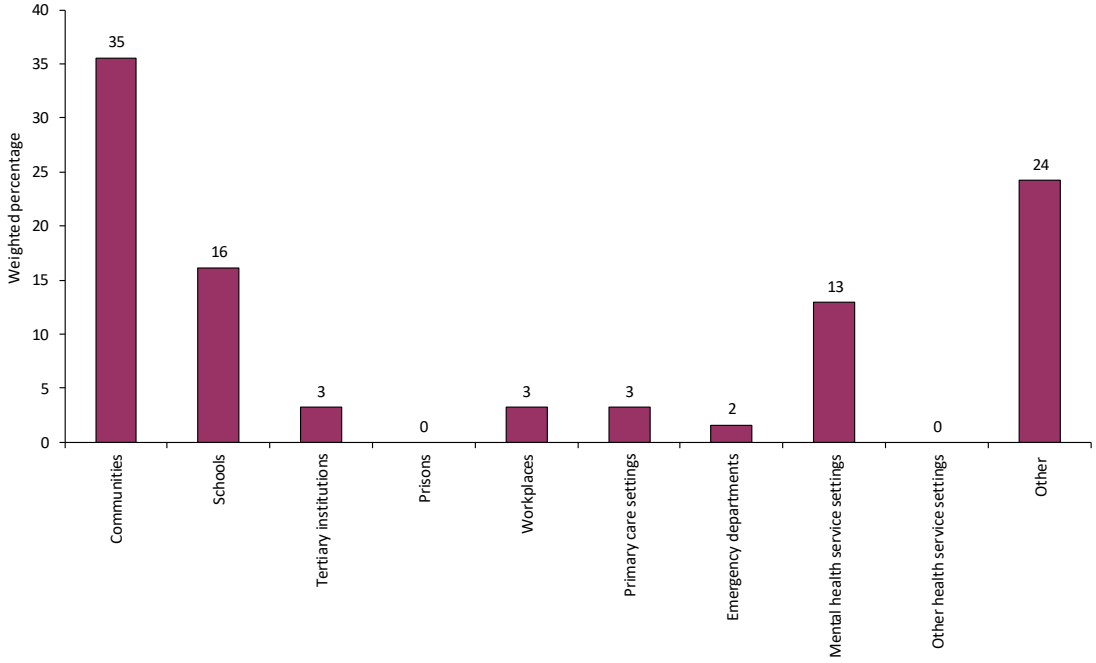
Figure 16: Grants and fellowships provided for suicide prevention research, by target group (n=28)



Setting

Figure 17 shows the research settings associated with the 31 grants for which this information was available. Certain settings took precedence. Thirty five per cent were concerned with community settings, 16% with schools, 13% with mental health service settings, and 24% with other settings (such as the internet). Tertiary institutions, workplaces and primary care settings each accounted for the settings in a further 3% of these grants and fellowships.

Figure 17: Grants and fellowships provided for suicide prevention research, by setting (n=31)



Chapter 4: Web-based questionnaire (Study 3)

Method

As noted in Chapter 1, the web-based questionnaire was designed to elicit stakeholders' views on future research priorities. Stakeholders were selected on the basis of their membership of groups with a known interest in suicide prevention research. More detail is provided below about the nature and conduct of the questionnaire, the sampling and recruitment strategy, and the data analysis strategy. Information on response rates for each group is also presented wherever possible.

The questionnaire

We adapted the questionnaire from our 2006 project to elicit stakeholders' views on where future priorities in suicide prevention should lie. The questionnaire asked stakeholders to consider each of the classifications listed below, and, within each classification, indicate which category they ranked as being of the highest priority.

- **Research type** (assessment studies; epidemiological studies; intervention studies; evaluation of policies/programs/services; biological research; social science studies; other);

- **Suicidal behaviour** (suicide; attempted suicide; suicidal thoughts; other);

- **Suicide method** (poisoning by drugs; poisoning by other; hanging; firearms; drowning; jumping from a high place; jumping or lying before a moving object; other);

- **Target group** (young people; adults; older people; Indigenous people; people from culturally and linguistically diverse backgrounds; people in rural and remote areas; people bereaved by suicide; people who are gay, lesbian, bisexual, transgender or intersex; people with mental health problems; people with physical health problems; people with substance use problems; people who have attempted suicide; offenders; men; women; current or ex-serving military personnel; other); and

- **Setting** (communities; schools; tertiary institutions; prisons; workplaces; primary care settings; emergency departments; mental health service settings; other health service settings; other).

The questionnaire also asked stakeholders a small number of socio-demographic questions and questions about their interest in suicide prevention research and their affiliations with the various groups we were targeting.

The questionnaire was made available online; there was no option for completing a paper-based version of the questionnaire. A copy of the questionnaire is included in Appendix C. Study 3 received ethical approval from the Human Research Ethics Committee at the University of Melbourne.

Stakeholder identification and recruitment

Stakeholders were selected on the basis of their membership of 15 groups known to conduct, fund, or use suicide prevention research (in clinical practice or in policy-making/planning activities), as well as those who are affected by suicide and/or provide advocacy for people who

have been affected by suicide. Table 6 details the stakeholder groups we targeted, and their major role in relation to suicide prevention research. It is acknowledged that some groups may play additional roles.

Table 6: Respondent groups and their major role in relation to suicide prevention research

ROLE IN RELATION TO SUICIDE PREVENTION RESEARCH	GROUP
People who conduct suicide prevention research	Researchers
People who use suicide prevention research (in clinical practice)	Psychiatrists
	General practitioners
	Psychologists
	Mental health nurses
	Alumni of the Australian Institute for Suicide Research and Prevention (AISRAP)
People who use suicide prevention research (in policy-making/planning activities)	Members of the Australian Advisory Group on Suicide Prevention (AAGSP)
	Members of the Mental Health, Drug and Alcohol Principal Committee (MHDAPC)
	Commonwealth and state/territory senior bureaucrats with responsibility for suicide prevention
	Primary Health Network (PHN) Suicide Prevention Managers
People involved in funding suicide prevention research	Members of the Australian Rotary Health Research Committee (ARH RC)
	Members of the Society for Mental Health Research Executive Committee (SMHR EC)
People who are affected by suicide and/or provide advocacy for those who have been affected by suicide	Members of Suicide Prevention Australia's Speakers Bureau (SPA SB)
	Members of Suicide Prevention Australia (SPA)
	Members of Roses in the Ocean (RITO)

Members of each group received an invitation to complete the questionnaire. The invitation included a group-specific embedded link to the questionnaire which enabled us to identify the group from which a respondent came, but not the individual respondent. The precise way in which the invitation was sent depended on the nature and operation of the group (e.g., whether it was represented by an organisation). In some cases, the invitation was sent by us (as an email with an embedded link to the online questionnaire). In others, it was sent by the relevant organisation, either as an email or as an electronic newsletter, again with an embedded link to the questionnaire. In still others, the invitation and the embedded link were posted on the relevant organisation's website. Table 7 provides information about the recruitment strategy for each group.

Table 7: Sampling and recruitment strategy, by group

GROUP	SAMPLING AND RECRUITMENT STRATEGY
Researchers	Identified by study team from list of Australian first and/or corresponding authors of peer-reviewed suicide prevention journal articles published between 2010 and 2017, for whom current email addresses were available. Approach made directly by study team, via email with web-link to questionnaire. Invited to complete web-based questionnaire. Two reminders sent.
Psychiatrists	Study invitation (including web-link to questionnaire) circulated to RANZCP membership base via Psyche newsletter. No reminder sent.
General practitioners	Study invitation (including web-link to questionnaire) circulated to members of the General Practice Mental Health Standards Collaboration (GPMHSC) via E-newsletter (goes out to GPs with an interest in mental health). No reminder sent.
Psychologists	Study invitation (including web-link to questionnaire) circulated via APS Matters newsletter, and posted on APS Research opportunities webpage (open to APS members and wider public). One reminder sent.
Mental health nurses	Study invitation (including web-link to questionnaire) circulated via ACMHN newsletter, posted on ACMHN webpage (open to ACMHN members and wider public) and on the ACMHN Facebook page. No reminder sent.
Alumni of the Australian Institute for Suicide Research and Prevention (AISRAP)	Identified and invited by AISRAP, via email with web-link to questionnaire. One reminder sent.
Members of the Australian Advisory Group on Suicide Prevention (AAGSP)	Identified and invited by National Mental Health Commission (NMHC) staff, via email with web-link to questionnaire. No reminder sent.
Members of the Mental Health, Drug and Alcohol Principal Committee (MHDAPC)	Identified by MHDAPC Secretariat, who emailed study invitation (including web-link to questionnaire) to MHDAPC members. One reminder sent.
Commonwealth and state/territory senior bureaucrats with responsibility for suicide prevention	Identified by MHDAPC Secretariat. Approach made directly by study team, via email with web-link to questionnaire. One reminder sent.
Primary Health Network (PHN) Suicide Prevention Managers	Identified and invited directly by study team, via email with web-link to questionnaire. Two reminders sent.
Members of the Australian Rotary Health Research Committee (ARH RC)	Identified by ARH RC. Approach made directly by study team, via email with web-link to questionnaire. Two reminders sent.
Members of the Society for Mental Health Research Executive Committee (SMHR EC)	Identified and invited directly by study team, via email with web-link to questionnaire. Two reminders sent.
Members of Suicide Prevention Australia's Speakers Bureau (SPA SB)	Identified and invited by SPA staff, via email with web-link to questionnaire. Two reminders sent.
Members of Suicide Prevention Australia (SPA)	Identified and invited by SPA staff, via email with web-link to questionnaire. Two reminders sent.
Members of Roses in the Ocean (RITO)	Identified by RITO. Approach made directly by study team, via email with web-link to questionnaire. Two reminders sent.

Invitations were progressively sent to the different groups from 24 July 2017. Wherever possible and appropriate, up to two reminders were sent.

Data management and analysis

Questionnaire data were downloaded into an Excel spreadsheet and then imported into SPSS for analysis. We downloaded data for the period from 24 July 2017 to 2 October 2017.

All key analyses are reported as simple frequencies and percentages. For the purposes of the current report, we have reported high-level, aggregated results for the entire respondent group, as well as more fine-grained breakdowns of the questionnaire data by relevant sub-groups.

Respondent numbers and response rates

The questionnaire was completed by a total of 390 respondents. A given individual may have received and completed the questionnaire as a member of one group but may also have been affiliated with several other groups. It would have been unreasonable to ask any individual to complete the questionnaire more than once, so we asked them to indicate which other groups they belonged to. This meant that we could calculate group-based response rates (for groups for which a denominator was available) based on returned questionnaires, knowing that these would be underestimates, and could then recalculate response rates taking into account respondents' additional affiliations. Table 8 shows response rates for each primary group (with and without additionally indicated affiliations) for which we had a denominator. These groups were typically those that were invited via email (either by us or by the organisation to which they belonged), and the number of individuals on the email list constituted the denominator. We could not determine denominators for groups whose members were approached in more diffuse ways (e.g., via newsletters or websites).

Overall, the response rate ranged from 5% for AAGSP members to 89% for MHDAPC members. Sixteen per cent of respondents conducted suicide prevention research; 55% used it; 2% were involved in funding it; and 28% had been affected by suicide or were providing advocacy.

Table 8: Response rates, by primary group and affiliations

Affiliations	Primary group														
	Researchers (191)	Psychiatrists (n/a)	GPs (n/a)	Psychologists (n/a)	Mental Health Nurses (n/a)	AAGSP (22)	MHDAPC (9)	CW/state/terr (7)	PHN (33)	ARH RC (10)	SMHR EC (14)	SPA (161)	SPA SB (75)	RITO (100)	AISRAP alumni (260)
Researcher	62	5	0	18	1	1	0	1	0	2	1	7	0	0	0
Psychiatrist	1	3	0	0	0	0	0	0	0	0	0	1	0	0	0
GP	1	0	16	0	0	0	0	0	0	0	0	0	0	0	0
Psychologist	4	0	0	114	2	0	0	4	0	0	0	5	1	1	0
MH Nurse	1	0	0	0	36	0	0	0	0	0	0	1	0	0	0
AAGSP	0	0	0	0	0	1	0	1	0	0	0	0	0	0	0
MHDAPC	1	2	0	1	1	0	8	5	0	0	0	0	0	0	0
CW/state/territory	0	0	0	1	0	0	0	3	0	0	0	0	0	0	0
PHN	0	0	0	1	0	0	0	2	10	0	0	0	0	0	0
ARH RC	1	0	0	1	0	0	0	0	0	3	0	0	0	0	0
SMHR EC	2	0	0	0	0	0	0	0	0	0	4	0	0	0	0
SPA	13	1	0	6	3	0	0	1	5	0	0	62	7	6	0
SPA SB	1	0	0	3	0	0	1	0	0	0	0	3	10	6	0
RITO	6	0	0	1	0	0	0	0	1	0	0	8	14	37	0
AISRAP alumni	8	0	0	7	1	0	0	2	0	0	1	4	0	0	21
Total primary group	62	3	16	114	36	1	8	3	10	3	4	62	10	37	21
Response rate group (%)	32	n/a	n/a	n/a	n/a	5	89	43	30	30	29	39	13	37	8
Total primary group + affiliations	101	11	16	153	44	2	9	19	16	5	6	91	32	50	21
Response rate primary group + affiliations (%)	53	n/a	n/a	n/a	n/a	9	100	271*	48	50	43	57	43	50	8

* Response rate exceeds 100% because some individuals erroneously indicated that they were Commonwealth or state/territory officers with responsibility for suicide prevention.

Results

Research type

Tables 9 and 10 show the high level and more specific research types rated by the various stakeholder groups as the highest priority for future suicide prevention research, respectively. The majority of stakeholder groups identified intervention studies as the highest priority, placing particular emphasis on studies of indicated interventions and, to a lesser extent, universal interventions. The next most commonly identified research type was epidemiological studies, especially studies of protective factors. Exceptions to this pattern were people who have been affected by suicide and/or provide advocacy, who rated epidemiological studies as being of greater priority than intervention studies, and people who use suicide prevention research in policy or planning, who gave most weight to social science studies.

Table 9: Research type rated as highest priority for suicide prevention research, by role of primary group (high level categories)

		People who conduct suicide prevention research	People who use suicide prevention research (clinical)	People who use suicide prevention research (policy/planning)	People involved in funding suicide prevention research	People who have been affected by suicide and/or provide advocacy	Total
		62	190	22	7	109	390
Assessment studies	n	6	16	1	0	4	27
	%	10	8	5	0	4	7
Epidemiology studies	n	15	58	5	2	44	124
	%	24	31	23	29	40	32
Intervention studies	n	27	79	5	4	31	146
	%	44	42	23	57	28	37
Evaluation studies	n	7	9	4	0	16	36
	%	11	5	18	0	15	9
Biological studies	n	1	9	0	0	1	11
	%	2	5	0	0	1	3
Social science studies	n	3	7	6	0	5	21
	%	5	4	27	0	5	5
Other studies*	n	3	12	1	1	8	25
	%	5	6	5	14	7	6

* Other studies identified by respondents included qualitative lived experience research, education, psychological studies, adoptee suicide studies, euthanasia and assisted suicide research, social media research, mindfulness studies and research focused on specific socio-cultural topics.

Table 10: Research type rated as highest priority for suicide prevention research, by role of primary group (lower level categories)

		People who conduct suicide prevention research	People who use suicide prevention research (clinical)	People who use suicide prevention research (policy/planning)	People involved in funding suicide prevention research	People who have been affected by suicide and/or provide advocacy	Total
		62	190	22	7	109	390
Studies re. assessment of suicide risk	n	6	16	1	0	4	27
	%	10	8	5	0	4	7
Studies of rates	n	1	5	1	0	6	13
	%	2	3	5	0	6	3
Studies of risk factors	n	1	19	1	2	15	38
	%	2	10	5	29	14	10
Studies of protective factors	n	13	34	3	0	23	73
	%	21	18	14	0	21	19
Studies re. general intervention issues/methods	n	5	11	0	0	7	23
	%	8	6	0	0	6	6
Studies re. practice guidelines	n	0	3	1	0	1	5
	%	0	2	5	0	1	1
Studies re. efficacy of universal interventions	n	6	17	1	2	6	32
	%	10	9	5	29	6	8
Studies re. efficacy of selective interventions	n	7	12	0	1	6	26
	%	11	6	0	14	6	7
Studies re. efficacy of indicated interventions	n	9	36	3	1	11	60
	%	15	19	14	14	10	15
Policy evaluations	n	1	2	0	0	1	4
	%	2	1	0	0	1	1
Program evaluations	n	4	3	4	0	14	25
	%	7	2	18	0	13	6
Service evaluations	n	2	4	0	0	1	7
	%	3	2	0	0	1	2

		People who conduct suicide prevention research	People who use suicide prevention research (clinical)	People who use suicide prevention research (policy/planning)	People involved in funding suicide prevention research	People who have been affected by suicide and/or provide advocacy	Total
Neurobiological studies	n	1	8	0	0	1	10
	%	2	4	0	0	1	3
Genetic studies	n	0	1	0	0	0	1
	%	0	1	0	0	0	0
Sociological studies	n	3	4	4	0	4	15
	%	5	2	18	0	4	4
Historical studies	n	0	1	1	0	1	3
	%	0	1	5	0	1	1
Literature / arts studies	n	0	0	1	0	0	1
	%	0	0	5	0	0	0
Media studies	n	0	2	0	0	0	2
	%	0	1	0	0	0	1
Other studies	n	3	12	1	1	8	25
	%	5	6	5	14	7	6

Suicidal behaviour

When asked to consider the suicidal thoughts and behaviours that should be given highest priority in future research, stakeholders most commonly endorsed suicide attempts, followed by suicide (see Table 11). The exception was people involved in funding suicide prevention research, who indicated that suicidal thoughts should be the priority.

Suicide method

Table 12 shows the priority ratings given to studies of various methods of suicide, by stakeholder group. Hanging followed by poisoning by drugs were the methods identified as warranting the greatest attention by most respondents. This pattern held for all groups except people involved in funding suicide prevention research, who identified poisoning by drugs as the top research priority.

Target group

Table 13 profiles the ratings given to particular target groups in terms of the research effort that they should be afforded. Overall young people were rated as the group which should be the highest research priority. Indigenous people and people who have attempted suicide were identified as the second and third highest priority groups overall. Again, there were some exceptions to this general rule, with, for example, those who conduct suicide prevention research rating people with mental health problems as the second highest priority group.

Setting

Communities were the setting most commonly identified as the highest priority for suicide prevention research (see Table 14). Schools and mental health service settings were also identified as research settings which should be prioritised. People who have been affected by suicide and/or provide advocacy also identified workplaces and emergency departments as locations which should be given priority.

Table 11: Suicidal behaviour rated as highest priority for suicide prevention research, by role of primary group

		People who conduct suicide prevention research	People who use suicide prevention research (clinical)	People who use suicide prevention research (policy/planning)	People involved in funding suicide prevention research	People who have been affected by suicide and/or provide advocacy	Total
	N	62	190	22	7	109	390
Suicide	n	24	56	5	2	32	119
	%	39	30	23	29	29	31
Attempted suicide	n	26	93	12	1	52	184
	%	42	49	55	14	48	47
Suicidal thoughts	n	9	32	4	4	19	68
	%	15	17	18	57	17	17
Other suicidal behaviour*	n	3	9	1	0	6	19
	%	5	5	5	0	6	5

*Other suicidal behaviour identified by respondents included isolation, withdrawal, mental health concerns and self harm.

Table 12: Suicide method rated as highest priority for suicide prevention research, by role of primary group

		People who conduct suicide prevention research	People who use suicide prevention research (clinical)	People who use suicide prevention research (policy/planning)	People involved in funding suicide prevention research	People who have been affected by suicide and/or provide advocacy	Total
	N	62	190	22	7	109	390
Poisoning by drugs	n	17	64	7	5	19	112
	%	27	34	32	71	17	29
Poisoning by other (e.g., poisoning by other gases and vapours, such as motor vehicle exhaust)	n	3	7	0	0	2	12
	%	5	4	0	0	2	3
Hanging (e.g., strangulation & suffocation)	n	28	80	12	0	64	184
	%	45	42	55	0	59	47
Firearms (includes explosives)	n	3	9	0	0	5	17
	%	5	5	0	0	5	4
Drowning	n	0	0	0	0	0	0
	%	0	0	0	0	0	0
Jumping from a high place	n	5	6	1	0	8	20
	%	8	3	5	0	7	5
Jumping or lying before a moving object	n	3	10	0	1	2	16
	%	5	5	0	14	2	4
Other*	n	3	14	2	1	9	29
	%	5	7	9	14	8	7

* Other suicidal behaviour that was specified by respondents included single person motor vehicle accidents (n=6) and cutting (n=3), whilst 12 respondents indicated that all suicidal behaviour was important regardless of method.

Table 13: Target group rated as highest priority for suicide prevention research, by role of primary group

		People who conduct suicide prevention research	People who use suicide prevention research (clinical)	People who use suicide prevention research (policy/planning)	People involved in funding suicide prevention research	People who have been affected by suicide and/or provide advocacy	Total
	N	62	190	22	7	109	390
Young people (aged 24 or less)	n	18	57	5	3	31	114
	%	29	30	23	43	28	29
Adults (aged 25-64)	n	6	21	2	0	19	48
	%	10	11	9	0	17	12
Older people	n	1	3	1	0	1	6
	%	2	2	5	0	1	2
Indigenous people	n	6	23	7	2	20	58
	%	10	12	32	29	18	15
People from culturally and linguistically diverse backgrounds	n	2	0	0	0	0	2
	%	3	0	0	0	0	1
People in rural and remote areas	n	3	6	0	0	3	12
	%	5	3	0	0	3	3
People bereaved by suicide	n	1	2	0	0	3	6
	%	2	1	0	0	3	2
People who are gay, lesbian, bisexual, transgender or intersex	n	2	4	1	0	2	9
	%	3	2	5	0	3	2
People with mental health problems	n	7	19	0	0	6	32
	%	11	10	0	0	6	8
People with physical health problems	n	1	1	0	0	0	2
	%	2	1	0	0	0	1
People with substance use problems	n	2	0	1	0	0	3
	%	3	0	5	0	0	1
People who have attempted suicide	n	6	28	1	1	17	53
	%	10	15	5	14	16	14

Offenders	n	0	1	0	0	0	1
	%	0	1	0	0	0	0
Men	n	5	5	2	1	3	16
	%	8	3	9	14	3	4
Women	n	0	0	0	0	0	0
	%	0	0	0	0	0	0
Current or ex-serving military personnel	n	0	9	1	0	0	10
	%	0	5	5	0	0	3
Other*	n	2	11	1	0	4	18
	%	3	6	5	0	4	5

*Four respondents indicated all suicides are of equal importance. Other target groups that were specified included adoptees, asylum seekers, current and ex-emergency service workers, new mothers, unemployed and low socioeconomic status individuals.

Table 14: Setting rated as highest priority for suicide prevention research, by role of primary group

		People who conduct suicide prevention research	People who use suicide prevention research (clinical)	People who use suicide prevention research (policy/planning)	People involved in funding suicide prevention research	People who have been affected by suicide and/or provide advocacy	Total
	N	62	190	22	7	109	390
Communities	n	18	50	7	6	37	118
	%	29	26	32	86	34	30
Schools	n	10	39	1	1	20	71
	%	16	21	5	14	18	18
Tertiary institutions	n	1	3	0	0	3	7
	%	2	2	0	0	3	2
Prisons	n	1	2	0	0	1	4
	%	2	1	0	0	1	1
Workplaces	n	1	7	1	0	13	22
	%	2	4	5	0	12	6
Primary care settings	n	6	24	7	0	9	46
	%	10	13	32	0	8	12
Emergency departments	n	8	22	1	0	13	44
	%	13	12	5	0	12	11
Mental health service settings	n	14	32	2	0	8	56
	%	23	17	9	0	7	14
Other health service settings	n	1	2	0	0	0	3
	%	2	1	0	0	0	1
Other*	n	2	9	3	0	5	19
	%	3	5	14	0	5	5

*Other settings that were specified included defence settings, emergency housing, youth services, shopping centres and private homes

Chapter 5: Discussion

Investment and outputs

During the eight-year period between 2010-2017, 424 journal articles have been published in the peer-reviewed literature that qualify as research where suicide is the primary focus. During the same period, 36 grants and fellowships have been funded to the tune of $10,580,619 in the area of suicide prevention.

This represents a near doubling of the total number of journal articles published and research funding awarded when compared to our previous eight-year study period of 1999-2006[5] (during which 263 articles had been published and 36 grants were awarded with a total value of $5,839,341).[b]

Although these rising figures reflect positively on the growing recognition of the major public health burden of suicide in Australia over the last decades, they arguably still fall short of being commensurate with the high individual, societal and economic burden of suicide and suicidal behaviours.

Summary of current and future priorities

Priorities for type of research

The profiles of published literature and funded grants and fellowships were relatively similar in terms of the type of research they involved. In both cases, the majority of research was epidemiological, with a focus on descriptive analyses of rates.

This profile of current priorities is somewhat at odds with where stakeholders believe that future priorities should lie. Stakeholders who completed the questionnaire emphasised the need for intervention studies (particularly studies of indicated interventions, and, to a lesser extent, studies of universal interventions). They did not discount epidemiological studies, but suggested that they should involve an increased focus on protective factors.

Priorities for suicidal behaviour

The published journal articles and funded grants and fellowships tended to relate to suicide, suggesting this is the suicidal behaviour that has been given current priority over attempted suicide and suicidal thoughts.

By contrast, stakeholder identified research priorities primarily highlighted the need for future research into attempted suicide (followed by research into suicide, and suicidal thoughts).

[b] The current review of funded grants and fellowships considered one additional funding body (SMHR), compared to our earlier study, but total grant funding for the three funding bodies examined across both studies (i.e., NHMRC, ARH, ARC) rose from $5,839,341 in 1999-2006 to $10,260,619 in 2010-2017.

Priorities for suicide method

Relatively few of the retrieved journal articles focused on particular suicide methods, but those that did tended to consider poisoning by drugs and hanging. None of the funded grants and fellowships appeared to be about specific suicide methods.

Stakeholders identified hanging as their highest ranked future research priority.

Priorities for target groups

Young people were the most commonly-researched target group in both the published literature and funded grants and fellowships, followed by people with mental health problems.

Stakeholders indicated that the emphasis on young people was appropriate and should be carried through as a future priority. Their views were mixed as to the priority that should be afforded to other groups, but suggested that Indigenous people, adults, people who have attempted suicide and people with mental health problems warrant attention.

Priorities for settings

Certain settings took precedence in the research published in the peer-reviewed literature and funded through grants and fellowships. Workplaces, mental health service, and other health service settings received particular emphasis in journal articles, while grants and fellowships were primarily associated with research in community, school and mental health service settings.

Settings identified by stakeholders as being priorities for future research included communities first and foremost, but also schools, mental health service settings, primary care settings, and emergency departments.

Comparison between priorities identified in 1999-2006 and priorities identified in 2010-2017

For the most part, the patterns of current and future priorities identified in this project mirror those we identified in our earlier project.[5] In the previous project, as in this one, we found that the current emphases appeared to be on epidemiological studies of suicide, often focusing on young people and occurring in a range of settings and rarely emphasising a single suicide method. Similarly, we found that stakeholders' views of future priorities were somewhat at odds with the apparent status quo, with our questionnaire respondents emphasising intervention studies, studies of attempted suicide, and studies of hanging and poisoning by drugs. They had mixed views on the target group that should be afforded the greatest priority, but a majority ranked young people as number one.[5]

What this suggests is that a number of the priorities identified by stakeholders in our previous project have not been realised. If anything, the gap between existing priorities and those identified by stakeholders may have increased in some areas. For example, a greater proportion of the funded grants and fellowships identified in the previous project were for intervention studies than was the case in the current project. This suggests that there may have been a shift in funding away from these sorts of studies, despite the importance placed on them by stakeholders.

Implications of the findings for the national research agenda

The current findings provide some guidance as to the direction that Suicide Prevention Australia might take in terms of distributing the $12 million national Suicide Prevention Research Fund. They also point to particular directions that our own Centre for Mental Health might take in providing its national leadership role in suicide prevention research.

The findings suggest that priority should be given to funding studies that evaluate interventions. Our collective understanding of what works (and what doesn't work) in suicide prevention is still insufficient, and it is crucial that we bolster this understanding if we are to move the suicide prevention field forward. It is only through examining the effectiveness – and ideally the cost-effectiveness – of interventions that our knowledge in this area will increase.

It makes sense to consider the full gamut of interventions but to perhaps give particular emphasis to indicated interventions, as suggested by stakeholders. Indicated interventions target those who are actively experiencing suicidal thoughts and/or engaging in self-harming behaviours, and there is an argument that getting these interventions right will have the greatest impact, at least in individual terms.

The findings also suggest that we should perhaps be more circumspect about the kinds of epidemiological studies that we support. A considerable amount of the current research effort has been on studies of rates of suicide among particular population groups and on factors that heighten suicide risk. As the stakeholders in our study indicated, future epidemiological studies should focus on creating new knowledge, particularly regarding protective factors. Answering questions about protective factors and the mechanisms by which they operate could make a significant contribution.

There is an argument that suicide prevention research should be broadened to include additional studies on suicide attempts, as requested by stakeholders. There is much to be learned from people who have survived suicide attempts.

The findings are perhaps less clear when it comes to priorities relating to target groups, suicide methods and settings. Existing research focuses on a variety of target groups and settings and rarely considers a single suicide method, and stakeholders had mixed views about where future efforts should be invested. Additional information is required to guide decisions in these areas. For example, decisions about the attention that should be afforded to particular target groups might be influenced by objective measures of the significance of the problem for them – e.g., group specific rates, indices of relative risk, indices of population attributable risk, and measures of burden. Similarly, decisions about which settings to choose as priorities for suicide prevention research might be based on factors like the extent to which particular settings contribute to or mitigate suicide risk, and the extent to which interventions might be delivered through them. Likewise, the relative emphasis that might be given to studies of particular suicide methods might be determined by criteria like the proportion of suicides (or attempted suicides) that are accounted for by them, and the extent to which they might be amenable to intervention (e.g., through means restriction).

Some caveats

Several caveats should be borne in mind in interpreting the above findings and considering what they mean for the national suicide prevention research agenda.

Assessing current priorities

The review of published literature drew on peer-reviewed journals only, and it is acknowledged that this strategy would have missed research reported in the 'grey' literature. We considered this was defensible, because it provided a non-arbitrary sampling frame and afforded some check on the quality of reported research, but it would have resulted in an under-count of published literature.

The review of grants and fellowships was restricted to those that were funded by Australia's key competitive granting bodies, which means that it would have missed research funded by governments or other bodies. Even the grants and fellowships funded by competitive granting bodies would have been under-represented because we were dependent on information that was publicly available on these organisations' websites, and information for some funding schemes was not available for the full eight-year period.[c] Again, this would have produced an undercount.

It was beyond the scope of the reviews to retrieve full journal articles or complete grant and fellowship proposals, and instead we relied on abstracts and summaries, respectively. In the main, this précis information was sufficient to make judgements according to the framework articulated in Chapter 1 for examining current priorities in suicide prevention research, but it is acknowledged that in some instances detail was lacking.

Assessing future priorities

The examination of future priorities relied solely on stakeholders' views of where ongoing effort should be placed. Stakeholder views are obviously important, but ideally other relevant factors would have been taken into account in assessing future priorities.

Stakeholders were selected in a manner designed to ensure that they were representative of people who conduct, use or fund suicide prevention research, as well as those who are affected by suicide and/or provide advocacy. However, the questionnaire response rates varied by group, and the purposive sampling strategy used relied on our team's knowledge of people and organisations with an interest in suicide prevention. In addition, stakeholders had varying degrees of knowledge about what is happening (and should be happening) in suicide prevention research in Australia. For these reasons, some caution should be exercised in generalising the views of questionnaire respondents to other stakeholders.

Conclusions

The recent Australian Government emphasis on supporting suicide prevention research has been welcomed by the sector. There is an acknowledgement that strengthening the evidence base could be a game-changer in terms of how we approach suicide prevention, and the key to this is ensuring that the research we do addresses the right questions. The current priority-setting exercise has helped to shed light on some of the gaps in suicide prevention research that stakeholders want to see filled. In particular, it has demonstrated that there is a relative dearth of intervention studies and studies that might help us to develop effective interventions (e.g., studies that tease out the factors that are protective against suicide and suicidal behaviour that might be promoted via appropriate interventions). Mechanisms to support research in these areas are likely to lead to significant knowledge gains.

[c] We know, for example, that the NHMRC funded a Centre of Research Excellence (CRE) in Suicide Prevention in 2013, but details of CRE funding were only available on the NHMRC website from 2014 onwards.

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Appendix A: List of peer-reviewed journal articles in which suicide or suicidal behaviour was the primary focus

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Appendix B: List of funded grants

National Health and Medical Research Council

1. Bainbridge R. Psycho-social resilience, vulnerability and suicide prevention: A mentoring approach to modifying suicide risk for remote Indigenous students at boarding school, 2014.
2. Borschmann R. Suicide and self-harm in young people in Australia, 2016.
3. Calear A. Suicide prevention in schools: A social connectedness approach, 2015.
4. Calear A. Preventing suicide in young people: A public health approach, 2017.
5. Chitty K. Can pharmacotherapy prevent alcohol driven suicides?, 2017.
6. Christensen H. Reducing suicide ideation: A randomised controlled trial of a novel web intervention, 2013.
7. Jorm A. Development of gatekeeper training to improve the capacity of Aboriginal and Torres Strait Islander communities to prevent youth suicide, 2014.
8. Pirkis J. An individual-level study of suicide method substitution over time, 2010.
9. Pirkis J. Building the evidence base for suicide prevention: The Victorian Suicide Register, 2013.
10. Pirkis J. Improving the evidence base for suicide prevention initiatives, 2014.
11. Robinson G. Skills for Life: A Life Skills curriculum for Indigenous youth in remote communities, 2014.
12. Robinson J. Developing social media based approaches to youth suicide prevention, 2015.
13. Shand F. Using an app for suicide prevention amongst young Indigenous people: A randomised controlled trial, 2014.
14. Toombs M. Indigenous Network Suicide Intervention Skills Training (INSIST): Can a community designed and delivered framework reduce suicide/self-harm in Indigenous youth?, 2014.

Australian Rotary Health

1. Batterham P. A Randomised Controlled Trial testing the effectiveness of a fully-tailored adaptive intervention in reducing mental health symptoms among young people, 2015.
2. Calear A. Silence is Deadly: A cluster-randomised controlled trial of a mental health help-seeking intervention for young men, 2017.
3. Christensen H. Living with deadly thoughts: Reducing suicidal thoughts through a web based self help intervention, 2012.
4. Furlong S. Using a multi-level nation-wide approach to improve the identification of young people at risk for suicide and motivate them to access and engage with appropriate treatment, 2016.
5. Handley T. Suicide in Australia: Determinants, moderators and treatment options for suicidal thoughts and behaviours, 2010.
6. Handley T. Multi-tiered approach to suicide prevention in young Australians, 2014.
7. Hill N. Suicide and self-harm hospitalisations among young people in Tasmania: An epidemiological study of suicide risk and the provision of care in the acute settings, 2017.
8. Hunt T. The development and trial of a training program to optimise telephone crisis-line outcomes with suicidal men, 2014.
9. Malhi G. Preventing suicide in young Australians with mood disorders: Adjunctive Lithium for Acute Suicidality (AliAS) study, 2017.
10. Middleton A. The development of an effective response for the management of suicidality in primary care for patients with depressive symptoms, 2013.

11. Pirkis J. Effective suicide prevention campaign material for young people: A randomised controlled trial, 2014.
12. Rees C. Group mindfulness based cognitive therapy vs group support for self-injury among young people: A pilot randomised controlled trial, 2015.
13. Spittal M. Detecting fatal and non-fatal suicide attempt clusters in young people, 2015.

Australian Research Council

1. Carpenter B. Investigating the coronial determination of suicide as a category of death, 2015.
2. De Leo D. Influences on farmer suicide in Queensland and New South Wales, 2012.
3. De Leo D. Bereavement of suicide and sudden death, 2014.
4. Keating B. Preventing railway suicide: An open-systems perspective, 2016.
5. Page A. A mental health "thermometer" to monitor and prevent adverse treatment outcomes and self-harm among psychiatric inpatients, 2010.

Society for Mental Health Research

1. Campbell G. Suicide and chronic pain in Australia: a retrospective mortality study, 2016.
2. Larsen M. RAFT: Reconnecting after a suicide attempt, 2015.
3. Milner A. Suicide in at risk occupational groups: the role of access to lethal means, 2015.
4. O'Dea B. Understanding suicide risk in Twitter: Applying the Interpersonal Theory of Suicidal Behaviour to a new frontier, 2015.

Appendix C: Questionnaire

National Survey of Suicide Prevention Research Priorities Questionnaire

Research Priorities in Suicide Prevention

Our team is working with Suicide Prevention Australia to seek the views of key stakeholders regarding where future suicide prevention research efforts should be focused.

Our team comprises:

- Professor Jane Pirkis – Director, Centre for Mental Health, University of Melbourne (Email: j.pirkis@unimelb.edu.au)
- Dr Lennart Reifels – Research Fellow, Centre for Mental Health, University of Melbourne (Email: l.reifels@unimelb.edu.au)
- Dr Maria Ftanou – Research Fellow, Centre for Mental Health, University of Melbourne (Email: mftanou@unimelb.edu.au)
- Dr Jo Robinson – Senior Research Fellow, Orygen: The National Centre of Excellence in Youth Mental Health (Email: jo.robinson@orygen.org.au)
- Dr Karolina Krysinska – Research Fellow, Centre for Primary Health Care and Equity, University of New South Wales (Email: k.krysinska@unsw.edu.au).

We would like to invite you to click on the button below and complete the questionnaire. Your responding is voluntary, and you will be free to withdraw at any time.

Your responses to the questionnaire will be anonymous. As you respond to the questionnaire, your responses will automatically be entered into a database which means that no hard copy of the questionnaire will need to be printed. The database will be kept on a password-protected computer in a locked office. All materials will be destroyed after a period of five years. When the findings from the questionnaire are presented publicly (e.g., at conferences or in reports or papers), care will be taken to make sure that you cannot be identified on the basis of your responses. Your responses will be anonymous.

I agree to participate

Australia has limited resources to put into suicide prevention research. Although it would be good if all types of research could be fully supported, in practice some priorities must be set. The purpose of this questionnaire is to find out what you think are the most important priorities. In a number of questions, you are asked to rate the priority which should be given to various areas of research as VERY LOW, LOW, MEDIUM, HIGH or VERY HIGH. **When making these ratings, please use the full range if possible. It will not help in setting priorities if you give the same rating to all areas.**

In making your ratings, please remember that you are **rating priorities for Australian suicide prevention research, rather than priorities for suicide prevention research worldwide.**

1a. Rate the following suicidal behaviours and thoughts in terms of how high a priority they should be for Australian suicide prevention research *[Tick one response per row]*

	Very low	Low	Medium	High	Very high
Suicide					
Attempted suicide					
Suicidal thoughts					
Other suicidal behaviour (please specify) _____					

1b. Of the above suicidal behaviours and thoughts, which do you think should be given the highest priority? *[Tick one response only]*

Suicide	
Attempted suicide	
Suicidal thoughts	
Other suicidal behaviour (as specified in Q1a)	

2a. Rate the following target groups in terms of how high a priority they should be for Australian suicide prevention research *[Tick one response per row]*

	Very low	Low	Medium	High	Very high
Young people (aged 24 or less)					
Adults (aged 25-64)					
Older people (aged 65 or more)					
Indigenous people					
People from culturally and linguistically diverse backgrounds					
People in rural and remote areas					
People bereaved by suicide					
People who are gay, lesbian, bisexual, transgender or intersex					
People with mental health problems					
People with physical health problems					
People with substance use problems					
People who have attempted suicide					
Offenders					
Men					
Women					
Current or ex-serving military personnel					
Other target group (please specify) _____					

2b. Of the above target groups, which do you think should be given the highest priority? *[Tick one response only]*

Young people (aged 24 or less)	
Adults (aged 25-64)	
Older people (aged 65 or more)	
Indigenous people	
People from culturally and linguistically diverse backgrounds	
People in rural and remote areas	
People bereaved by suicide	
People who are gay, lesbian, bisexual, transgender or intersex	
People with mental health problems	
People with physical health problems	
People with substance use problems	
People who have attempted suicide	
Offenders	
Men	
Women	
Current or ex-serving military personnel	
Other target group (as specified in Q2a)	

3a. Suicide prevention activities can be carried out in various settings. Rate the following settings in terms of how high a priority they should be for suicide prevention research *[Tick one response per row]*

	Very low	Low	Medium	High	Very high
Communities					
Schools					
Tertiary institutions					
Prisons					
Workplaces					
Primary care settings (e.g., general practice)					
Emergency departments					
Mental health service settings					
Other health service settings					
Other setting (please specify) _____					

3b. Of the above settings, which do you think should be given the highest priority? *[Tick one response only]*

Communities	
Schools	
Tertiary institutions	
Prisons	
Workplaces	
Primary care settings (e.g., general practice)	
Emergency departments	
Mental health service settings	
Other health service settings	
Other setting (as specified in Q3a)	

4a. Rate the following methods of suicide in terms of how high a priority they should be for suicide prevention research *[Tick one response per row]*

	Very low	Low	Medium	High	Very high
Poisoning by drugs					
Poisoning by other (includes poisoning by other gases and vapours, such as motor vehicle exhaust)					
Hanging (includes strangulation and suffocation)					
Firearms (includes explosives)					
Drowning					
Jumping from a high place					
Jumping or lying before a moving object					
Other method (please specify) _____					

4b. Of the above methods of suicide, which do you think should be given the highest priority? *[Tick one response only]*

Poisoning by drugs	
Poisoning by other (includes poisoning by other gases and vapours, such as motor vehicle exhaust)	
Hanging (includes strangulation and suffocation)	
Firearms (includes explosives)	
Drowning	
Jumping from a high place	
Jumping or lying before a moving object	
Other method (as specified in Q4a)	

5a. Rate the following types of studies in terms of how high a priority they should be for Australian suicide prevention research *[Tick one response per row]*

	Very low	Low	Medium	High	Very high
Studies about assessment or classification of suicide risk (including studies of the development or validation of risk assessment tools)					
Studies of rates of suicide, attempted suicide and/or suicidal thoughts					
Studies of risk factors for suicide, attempted suicide and/or suicidal thoughts					
Studies of protective factors for suicide, attempted suicide and/or suicidal thoughts					
Studies considering general intervention issues and approaches in suicide prevention					
Studies of practice guidelines					
Studies of the efficacy of universal interventions (i.e., interventions targeting whole populations, with the aim of favourably shifting risk and protective factors across the whole population)					
Studies of the efficacy of selective interventions (i.e., interventions targeting population subgroups with particular risk factors for suicide who are not yet exhibiting suicidal thoughts or behaviours)					
Studies of the efficacy of indicated interventions (i.e., interventions designed for people who are already beginning to exhibit suicidal thoughts or behaviours)					
Evaluations of suicide prevention policies					
Evaluations of suicide prevention programs					
Evaluations of services (e.g., health and/or community services)					
Neurobiological studies, including studies of brain anatomy and physiology and their relationship to suicide, attempted suicide and/or suicidal thoughts					
Genetic studies of suicide, attempted suicide and/or suicidal thoughts					
Sociological studies of suicide, attempted suicide and/or suicidal thoughts					
Studies of the history of suicide, attempted suicide and/or suicidal thoughts					
Studies of suicide, attempted suicide and/or suicidal thoughts in literature or the arts					
Studies of suicide, attempted suicide and/or suicidal thoughts in the media					
Other studies on suicide, attempted suicide and/or suicidal thoughts (please specify) _____					

5b. Of the above types of studies, which do you think should be given the highest priority?
[Tick one response only]

Studies about assessment or classification of suicide risk (including studies of the development or validation of risk assessment tools)	
Studies of rates of suicide, attempted suicide and/or suicidal thoughts	
Studies of risk factors for suicide, attempted suicide and/or suicidal thoughts	
Studies of protective factors for suicide, attempted suicide and/or suicidal thoughts	
Studies considering general intervention issues and approaches in suicide prevention	
Studies of practice guidelines	
Studies of the efficacy of universal interventions (i.e., interventions targeting whole populations, with the aim of favourably shifting risk and protective factors across the whole population)	
Studies of the efficacy of selective interventions (i.e., interventions targeting population subgroups with particular risk factors for suicide who are not yet exhibiting suicidal thoughts or behaviours)	
Studies of the efficacy of indicated interventions (i.e., interventions designed for people who are already beginning to exhibit suicidal thoughts or behaviours)	
Evaluations of suicide prevention policies	
Evaluations of suicide prevention programs	
Evaluations of services (e.g., health and/or community services)	
Neurobiological studies, including studies of brain anatomy and physiology and their relationship to suicide, attempted suicide and/or suicidal thoughts	
Genetic studies of suicide, attempted suicide and/or suicidal thoughts	
Sociological studies of suicide, attempted suicide and/or suicidal thoughts	
Studies of the history of suicide, attempted suicide and/or suicidal thoughts	
Studies of suicide, attempted suicide and/or suicidal thoughts in literature or the arts	
Studies of suicide, attempted suicide and/or suicidal thoughts in the media	
Other studies on suicide, attempted suicide and/or suicidal thoughts (as specified in Q5a)	

Finally, here are a few questions about yourself

6. What is your age? ***[Tick one response only]***

Under 20	
20-29	
30-39	
40-49	
50-59	
60-69	
70 or over	

7. What is your gender? ***[Tick one response only]***

Male	
Female	
Transgender	
Gender not specified	

8. Which of the following statements describe your interest in suicide prevention research? ***[Tick all that apply]***

I conduct suicide prevention research	
I use suicide prevention research (e.g., in clinical work or in policy-making/planning)	
I have been involved in decision-making regarding funding of suicide prevention research	
I have been affected by suicide	
Other (please specify) _____	

9. People were invited to complete this survey because of their affiliation with various groups. Which of the following statements describe the group(s) you belong to? *[Tick all that apply]*

I am a suicide prevention researcher	
I am a psychiatrist	
I am a general practitioner	
I am a psychologist	
I am a mental health nurse	
I am a member of the Australian Advisory Group on Suicide Prevention (AAGSP)	
I am a member of the Mental Health, Drug and Alcohol Principal Committee (MHDAPC)	
I am a Commonwealth or state/territory officer with responsibility for suicide prevention	
I am a Primary Health Network (PHN) Suicide Prevention Manager or Chief Executive Officer	
I sat on a National Health and Medical Research Council (NHMRC) Grant Review Panel (GRP) which assessed grants in a recent Targeted Call for Research (TCR) relevant to suicide prevention	
I am a member of the Australian Rotary Health (ARH) Research Committee	
I am a member of the Society for Mental Health Research (SMHR) Executive Committee	
I am a member of Suicide Prevention Australia (SPA)	
I am a member of the Suicide Prevention Australia (SPA) Lived Experience Network (LEN) Speakers Bureau	
I am a someone who has received training from Roses in the Ocean (RITO)	

10. Any additional comments?

THANK YOU FOR TAKING THE TIME TO COMPLETE THIS QUESTIONNAIRE.

If you experience distress as a result of issues raised by the questionnaire, you may wish to contact Lifeline on 13 11 14.