Suicide Prevention Australia

Policy Position Statement

Priority Populations

February 2023

Position

1. All suicide prevention initiatives, whether solely targeted at reducing suicides or with this as one of the aims, should identify priority populations for suicide prevention and ensure the needs of these populations are addressed.

2. The lived experience of people from priority populations should help guide suicide prevention activities preventing suicide for those cohorts.

3. When identifying priority populations the following should be considered:
   a. statistical data indicating a heightened risk of suicide
   b. experience of factors known to increase the risk of suicide
   c. barriers to accessing suicide prevention supports

4. Increased investment in supports and services for priority populations is needed, including additional funding allocated to National Suicide Prevention Leadership Support Program.

Context and Commentary

Suicide is a complicated and multi-factorial human behaviour and impacts on people from a broad range of ages, ethnicities, genders, sexual orientations and occupations. However, it is widely acknowledged that particular groups of people need to be specifically considered in initiatives to reduce suicide.[1]

As well as helping particular groups, a commitment to considering the needs of priority populations helps ensure that initiatives to reduce suicide are responsive to the needs of all people. The intention is not to focus only on particular groups, but to ensure that the diversity of needs is recognised and that the needs of all are taken into account in suicide prevention efforts.

In addressing the needs of priority populations, the voice and knowledge of individuals with lived experience from particular priority populations is essential to ensuring policies and practice meet the needs of those at-risk or impacted by suicide. People with lived experience should be integrated in all aspects of suicide prevention. Their leadership, knowledge and insights are uniquely placed to inform suicide prevention policy and practice.

[1] See, e.g., https://www.aihw.gov.au/suicide-self-harm-monitoring/data/populations-age-groups, https://lifeinmind.org.au/about-suicide/priority-populations

All initiatives that aim to reduce suicides should identify priority populations for suicide prevention, and ensure their needs are considered. This includes the design and delivery of support services, research activities, and strategic plans or frameworks. In addition, it includes not only specific suicide prevention initiatives, but also initiatives that have suicide prevention as one of the goals or intended outcomes. For these multi-aim initiatives that include suicide prevention it is important that priority populations, with regard to suicide prevention specifically, as well as for other aims, are identified. For example, a strategy on mental health and suicide prevention should identify males as a priority group, since although males have lower rates of mental health diagnosis over 75% of people that die by suicide are men.[2]

Which groups of people should be identified will vary depending on the initiative. For example, a service being delivered in a specific region may not contain certain groups (e.g. a service delivered in the central business district of a large city would not consider farmers as a priority group). And some initiatives may focus on a particular priority group, and while these will still need to consider relevant sub-groups and intersecting risks, they may not cover some groups (e.g. a youth suicide prevention strategy would need to consider Aboriginal and Torres Strait Islander young people, but would not need to consider males over age 85).

This policy position statement sets out a framework for identifying priority populations. It should be considered alongside the attached report summarising the existing evidence on priority populations and recent research on the risk of suicide across various groups. This report will be updated annually and is designed to provide a stocktake of available research rather than a definitive list of priority cohorts.[3]

Framework for identifying priority populations

A population should be identified as a priority for suicide prevention efforts if any one or more of the following is the case:

- there is statistical data indicating a heightened risk of suicide in that population
- the population experiences factors known to increase the risk of suicide
- the population faces barriers to accessing suicide prevention support

In many cases priority populations will be identified by two or all three of these, but any one is sufficient to justify efforts to ensure specific consideration of the needs of this population.

In addition, any populations where these will be present in the future, should be identified as a priority. Two examples of this are Australian Defence Force (ADF) members and children who have experienced abuse. Although members of the ADF do not have higher rates of death by suicide than the general population,[4] most ADF member (excepting those who die during their service) will become veterans. And veterans have higher rates of death by suicide than the general population.[5] Similarly, the numbers of deaths by suicide amongst children is very low,[6] but having experienced abuse is a known risk factor for suicide in adults,[7] so as they become adults they become a group at risk.

Statistical data on risk

There are a number of groups who are known or widely suspected to be at increased risk of suicide where statistical data is incomplete, unreliable, or completely unavailable. For example, there is a lack of comprehensive data for many LGBTIQ+ communities.[8] So statistical data cannot be the only way of identifying priority populations. However, where reliable statistical data does exist it is an important way of identifying priority populations.

[2] National Mental Health Commission, 2020. Monitoring Mental Health and Suicide Prevention Reform: National Report 2020. Sydney.
[3] [reference priority populations report]
[4] Australian Institute of Health and Welfare, 2021. Serving and ex-serving Australian Defence Force members who have served since 1985: suicide monitoring 2001 to 2019. Cat. no. PHE 290. Canberra: AIHW.
[5] Ibid.
[6] Australian Bureau of Statistics, 2021. Causes of Death, Australia, https://www.abs.gov.au/statistics/health/causes-death/causes-death-australia/latest-release
[7] Ng, Q.X., Yong, B.Z.J., Ho, C.Y.X., Lim, D.Y. and Yeo, W.S., 2018. Early life sexual abuse is associated with increased suicide attempts: an update meta-analysis. Journal of psychiatric research, 99, pp.129-141.
[8] Haas, A., Eliason, M., Mays, V., Mathy, R., Cochran, S., D'Augelli, A., Silverman, M., Fisher, P., Hughes, T., Rosario, M., Russell, S., Malley, E., Reed, J., Litts, D., Haller, E., Sell, R., Remafedi, G., Bradford, J., Beautrais, A., Brown, G., Diamond, G., Friedman, M., Garofalo, R., Turner, M., Hollibaugh, A. and Clayton, P., 2010. Suicide and Suicide Risk in Lesbian, Gay, Bisexual, and Transgender Populations: Review and Recommendations. Journal of Homosexuality, 58(1), pp.10-51.

There are a number of statistics that should be taken into account when identifying priority populations including:

- rates of death by suicide
- number of deaths by suicide
- frequency of death by suicide compared with other causes of death
- rates of suicide attempts
- number of suicide attempts
- prevalence of suicidal ideation

Experiencing risk factors

There are a number of factors that research has indicated are linked with increased risk of suicide.[9] Consideration of these factors identifies priority populations in two ways:

Firstly, there are a number of groups that research shows experience one or more risk factors at a higher rate than the general population. For example, Aboriginal and Torres Strait Islander people are disproportionately affected by a number of risk factors including: cultural and social exclusion, socioeconomic disadvantage, racism, higher rates of unemployment, mental illness and substance use.[10]

Secondly, the priority population may be defined by the risk factor. For example, there is a significant amount of research to show that survivors of previous suicide attempts are at a higher risk of death by suicide.[11] And survivors are a priority population who experience significant internal and external stigma, and high levels of psychological distress which contributes to the increased risk of death by suicide.[12]

Access barriers

In addition to considering the factors associated with increased risk of suicide, it is important to consider factors that can prevent groups from accessing suicide prevention support services. These can include:

- physical barriers
- language and literacy barriers
- culture/safety barriers

Physical barriers: These can include access barriers faced by those with disability, as well as barriers of distance or transport which can be experienced by groups such as those living in regional, rural or remote areas.

Language and literacy barriers: These include not only barriers for groups such as migrants and refugees who may have limited English, but also groups such as those with sensory or intellectual disabilities who may have particular needs in spoken or written communication.

Culture/safety barriers: Unsafe cultural practices can be defined as actions which diminish, demean or disempower the cultural identity and wellbeing of an individual.[13] This concept can be applied in the context of number of groups including indigenous, culturally and linguistically diverse, and LGBTIQ+.

[9] World Health Organization, 2014. Preventing suicide: A global imperative. World Health Organization, p31.
[10] Hunter, E. and Milroy, H., 2006. Aboriginal and Torres Strait Islander Suicide in Context. Archives of Suicide Research, 10(2), pp.141-157.
[11] Bostwick, J., Pabbati, C., Geske, J. and McKean, A., 2016. Suicide Attempt as a Risk Factor for Completed Suicide: Even More Lethal Than We Knew. American Journal of Psychiatry, 173(11), pp.1094-1100.
[12] Mcmenamy, J., Jordan, J. and Mitchell, A., 2008. What do Suicide Survivors Tell Us They Need? Results of a Pilot Study. Suicide and Life-Threatening Behavior, 38(4), pp.375-389.
[13] Nursing Council of New Zealand 2005. Guidelines for cultural safety, the treaty of Waitangi, and Maori health in nursing and midwifery education and practice. Wellington: Nursing Council of New Zealand.

Additional support and investment

The annual State of the Nation Report for the suicide prevention sector consistently highlights the need for additional support and investment directed at suicide prevention among priority populations at-risk. The 2022 report shows widespread support for additional funding for various priority populations, with almost 4 out of 5 respondents (78%) indicated priority populations were not appropriately funded, resourced or responded to.[14]

The National Suicide Prevention Leadership Support Program (NSPLSP) includes funding under Activity 7 to support for at risk populations and communities. This objective of the activity is to develop and deliver evidence-based suicide prevention support services that comprehensively reach at risk populations and communities. $65.5 million was allocated towards this activity over three years with per annum funding of $21.5 million in 2022-23, 2023-24 and 2024-25. The NSPLSP grant round was vastly oversubscribed additional investment is required to support priority cohorts.

[14] Suicide Prevention Australia, 2022. State of the Nation in Suicide Prevention: A survey of the suicide prevention sector, Suicide Prevention Australia.

Acknowledgements Statement

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If you or someone you know require 24/7 crisis support, please contact:

Lifeline: 13 11 12
www.lifeline.org.au

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

For general enquiries

02 9262 1130 | policy@suicidepreventionaust.org | suicidepreventionaust.org