CHAPTER 7

SUICIDE RESEARCH

Introduction

7.1 This chapter will deal with term of reference (g) the adequacy of the current program of research into suicide and suicide prevention, and the manner in which findings are disseminated to practitioners and incorporated into government policy.

NSPS suicide research

7.2 DoHA outlined three research projects which the Commonwealth Government had provided funding towards:

- the WHO Suicide Trends in At-Risk Territories study from 2008 -2010 to investigative preventative interventions across various countries, cultures and population sub groups within the Asia-Pacific region;
- University of Sydney case-control studies of suicides and attempted suicide in young adults in NSW commenced under a National Health and Medical Research Council (NHMRC) project grant; and
- the completed Australian National Epidemiological Study of Self-Injury project which aimed to determine the prevalence and nature of self-injury amongst the Australian population.[1]

7.3 In 2008 AISRP at Griffith University became a National Centre of Excellence in Suicide Prevention (NCESP) under the NSPS.

The purpose of the NCESP is to:

- provide advice on evidence-based best practice suicide prevention activity to inform the NSPP workplan, commencing with the ATAPS program, but also in relation to other activity, such as population health approaches to suicide prevention through school-based activity;
- offer direct support to agencies contracted by DoHA to undertake new and emerging suicide prevention activities, particularly where this pertains to selective interventions to individuals who have attempted suicide or self-harm;
- provide a quarterly critical literature review outlining recent advances and promising developments in research in suicide prevention, particularly where this can help to inform national activities;

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1 DoHA, *Submission 202*, pp 64 -66.

- provide advice on improving approaches to evaluation of suicide prevention activities and on the development of evaluation frameworks for new projects, such as the ATAPS suicide prevention project and other identified areas of the NSPS workplans; and
- provide advice on the implications of existing suicide prevention data and on issues around the credibility of suicide data.[2]

A focus on the evaluation of interventions

7.4 A number of the main suicide prevention organisations and others emphasised that Australia currently did not have a set of priorities for research into suicide and no systemic process for developing research priorities. Many submitters cited an article in *Crisis: Journal of Crisis Intervention & Suicide* which examined research priorities in suicide prevention in Australia. This article concluded:

> Well-conducted intervention studies are necessary to inform the suite of suicide prevention activities to be undertaken under the LIFE Framework. At present, we know very little about what works and what doesn't work in suicide prevention.
>
> Given the limited knowledge regarding which interventions might be efficacious, it would seem reasonable for attention to be paid to studies that assess the efficacy of the full spectrum of suicide prevention interventions (universal, selective, and indicated) and/or evaluate suicide prevention policies, programs, and services.[3]

7.5 This study of suicide prevention research also supported equal focus be placed on research into both suicide and attempted suicide. In relation to target groups for research it stated that young people were the most commonly researched and prioritised, as well as those with mental health problems and those who have attempted suicide and self harm. However it argued:

> It would seem premature, however, to prioritise only these groups over others, particularly since, as noted above, we know so little about what works and what doesn't work in terms of suicide prevention for *any* target group.[4]

7.6 The *Crisis* article reflects an earlier international systematic review of suicide interventions in 2005 which could only identify two prevention strategies for which

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2 DoHA, *Submission 202*, p. 64; AISRP, *Submission 237*, p. 109.

3 Jo Robinson et al, 'Research Priorities in Suicide Prevention in Australia; A Comparison of Current Research Efforts and Stakeholder-Identified Priorities', *Crisis: Journal of Crisis Intervention & Suicide*, 2008, vol. 29, no.4, p. 188.

4 Jo Robinson et al, 'Research Priorities in Suicide Prevention in Australia; A Comparison of Current Research Efforts and Stakeholder-Identified Priorities', *Crisis: Journal of Crisis Intervention & Suicide*, 2008, vol. 29, no. 4, p. 188.

there was evidence of effectiveness: educating physicians to detect, diagnose and manage depression and restricting access to lethal methods of suicide. The review did not reject other strategies as ineffective but found these interventions need more evidence of efficacy.[5]

7.7 The focus on the evaluations of interventions was widely supported. For example Lifeline Australia stated that in its experience there does not appear to be a mechanism to assess the efficacy of trials/pilot programs and if these should be implemented nationally as a sustainable funded service. Similarly SPA noted:

> …Australia's suicide and suicide prevention research agenda should more effectively emphasise and adopt the principle and practice of evaluations of specific suicide-related interventions, policies, programs and services.[6]

7.8 The MHCA argued:

> Unless measures are put in place to ensure that programs and policies are working, we will continue to see precious resources going to antiquated systems and failed programs; programs that have failed for many years to make significant inroads in reducing suicide rates, especially in high risk groups and communities. [7]

7.9 However there appeared to have been a lack of such evaluations of suicide prevention activities in the previous years. Associate Professor Jane Pirkis outlined research undertaken which reviewed the 156 projects funded under the original NSPS. While the organisations which received funding for these projects were contractually obligated to evaluate '…in practice the evaluations were methodologically too weak to contribute much to the evidence base regarding what works and what doesn't work in suicide prevention'.[8] Similarly AISRP highlighted that despite a broad range of programs funded by the Commonwealth and States only 60 per cent included an effectiveness evaluation component and none of those evaluated the impact of the interventions on the actual suicide rate.[9]

Difficulties assessing suicide interventions

7.10 It was acknowledged during the inquiry that evaluations of the effectiveness of suicide prevention inventions and initiative posed a numbers problems for

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5 Associate Professor Jane Pirkis, *Submission 27*, p. 1; J Mann et al, 'Suicide prevention strategies: a systematic review', *Journal of the American Medical Association*, 2005, vol. 294, p. 2064.

6 SPA, *Submission 121*, p. 61.

7 MHCA, *Submission 212*, op. 5.

8 Associate Professor Jane Pirkis, *Submission 27*, p. 1; A Heady et al, 'A review of the 156 local projects funded under Australia's National Suicide Prevention Strategy: overview and lessons learned', *Australian e-journal for the Advancement of Mental Health*, 2006, vol. 5, no. 3, p. 247.

9 AISRP, Submission 237, pp 106-107.

researchers. For example Orygen Youth Health Research Centre stated that while suicide and its associated sequelae represent a significant health problem it is a rare event '… which means that large numbers of participants are required for intervention studies to have sufficient power to enable meaningful conclusions to be drawn'. They suggested suicide research would benefit from the development of research networks which would facilitate the development of multi-site studies.[10]

7.11 Associate Professor Jane Pirkis also described the problems for researchers seeking to evaluate suicide interventions. Suicide prevention activities are usually not amenable to the 'gold standard' of randomised control trials. She argued that there needed to be recognition that '… some interventions, by their very nature, will not be amenable to randomised controlled trials but that we must apply the most rigorous designs that we can'.[11] AISRP also suggested that while controlled randomised trials were not always feasible in the domain of suicide prevention research '…other sound evaluation designs could be used, e.g. quasiexperimental designs using control groups'.[12]

7.12 The ethical issues of researching suicide prevention were also raised. The Suicide is Preventable submission stated that ethics committee approval processes would generally prohibit research involving any person who may be demonstrating suicidal behaviour.[13] SPA emphasised there was a paucity of evidence regarding what interventions work in suicide prevention but also noted these studies were difficult to complete. They commented:

> Ethical concerns arise with recruiting actively suicidal participants to intervention studies (e.g. antidepressant pharmacotherapy, psychotherapy) or alternatively excluding them from interventions… There are also major statistical problems with demonstrating a reduction of suicide, though these are not insurmountable…[14]

Disseminating research

7.13 The LIFE Communications project delivered by Crisis Support Services '…aims to improve the effectiveness of suicide and self-harm prevention activities in Australia by providing access to the latest information and shared learnings from the NSPS in suicide prevention, intervention and postvention'.[15] Components of the project include providing access to the LIFE suite of resources and access to the latest information activities and resources in suicide prevention. From June 2009 to

10 Orygen Youth Health Research Centre, *Submission 82*, p. 3.

11 Associate Professor Jane Pirkis, *Submission 27*, p. 3.

12 AISRP, *Submission 237*, p. 108.

13 Suicide is Preventable, *Submission 65*, p. 128.

14 SPA, *Submission 121*, p. 60.

15 DoHA, *Submission 202*, p. 63,

September 2009, 674 hard copies of the LIFE resource were distributed. Between June 2009 to October 2009 there were over 16,300 visits to the LIFE website.[16]

7.14 However there were some concerns raised during the inquiry about the dissemination of research. The Salvation Army had concerns that suicide research information was '…not readily accessible to practitioners within the health and welfare sectors'. They perceived a need to ensure that research was '… synthesised and incorporated into salient messages disseminated through mediums that will reach the front line staff who are working with people at risk of suicide'.[17]

7.15 In the area of suicide prevention Dr Erminia Colucci argued there was 'too much separation between academia and services'.[18] This was supported by Professor Colin Tatz who described the dissemination of suicide research material was 'frankly, dismal' noting that '…lay people don't read articles in *Australasian Psychiatry*; nor do many of the health professionals, educators and community workers who seek to prevent suicide'.[19] Psychotherapy and Counselling Federation of Australia members also reported that current research was inadequate and hard to access.[20]

7.16 The Integrated Primary Mental Health Service of North East Victoria also noted that statistical information about suicide is not routinely made available for clinical staff within their own geographical environment and contexts. They commented:

> As a service, we are often frustrated with a lack of clarity around accurate regional suicide statistics, and how to access them…. Improved dissemination of these statistics would be immensely helpful in supporting our delivery of evidenced-based mental healthcare.[21]

Resource Centre

7.17 Lifeline stated that 'Australia currently lacks a systematic formal mechanism for identifying, enabling and communicating information about best practice'. They proposed the creation of a best practice registry similar to one currently operating in the United States, the Suicide Prevention Resource Centre (SPRC).[22] The SPRC was established in 2002 and '…supports suicide prevention with the best of science, skills and practice to advance the United States National Strategy for Suicide Prevention (NSSP)'. It includes a best practice registry for suicide prevention to identify, review,

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16 DoHA, *Submission 202, Appendix D*, p. 23.

17 Salvation Army, *Submission 142*, p. 42.

18 Dr Erminia Colucci, *Submission 77*, p. 1.

19 Professor Colin Tatz, *Submission 16*, p. 1.

20 Psychotherapy and Counselling Federation of Australia, *Submission 72*, p. 9.

21 Integrated Primary Mental Health Service of North East Victoria, *Submission 26*, pp 3&6.

22 Lifeline Australia, *Submission 129*, pp 67-68.

and disseminate information about best practices that address specific objectives of the NSSP.[23]

7.18 SPA also argued that in many cases the information distributed on 'best practice' suicide prevention, intervention and postvention strategies is outdated. They stated it was essential for 'best practice' standards and accreditation for all service delivery and training. SPA recommended the development of an independent suicide prevention accreditation and standards agency 'to manage the accreditation and evaluation of suicide prevention service delivery, training and programs'.[24]

Gaps in research

7.19 Several submissions which discussed specific groups who were at risk of suicide also identified gaps in the research about these groups. For example, MHCA noted that the research priorities study 'revealed that, of 209 published journal articles and 26 funded grants undertaken between 1999 and 2006, none specifically targeted CALD populations ... Only 2% of people conducting suicide prevention research were identified as targeting CALD peoples.[25] Similarly the Victorian Institute of Forensic Mental Health argued that while there had been considerable research in suicide and prevention for prisoners in the 1990s little attention had been given to this issue in the past decade. They stated:

> With the number of prisoners in Australia increasing at unprecedented levels, it is vital that research into suicide and self harming behaviour within the criminal justice system be conducted to inform Government decision making. Specific issues in relation to women, the personality disordered and people with a multi-cultural background are specific areas that require close investigation.[26]

7.20 Ms Leonore Hanssens commented:

> There is a dearth of research into suicide contagion and clustering of suicides particularly in traditional Indigenous communities across Australia. There appears to be a reluctance to investigate the suicide deaths that are occurring in the Northern Territory particularly since the rates of suicide have accelerating dramatically.[27]

7.21 SPA listed a number of gaps in suicide and suicide prevention research including the coordination and communication between sectors and services to prevent individuals 'falling through the gaps'. They suggested mapping these gaps

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23 Available at www.sprc.org (accessed 30 April 2010)

24 SPA, Submission121, pp 48 & 51.

25 MHCA, *Submission 212*, p. 31.

26 Victorian Institute of Forensic Mental Health, *Submission 125*, p. 7.

27 Ms Leonore Hanssens, *Submission 83*, p. 3.

'may assist in better addressing them…'. They also suggested research into the lived experience from those affected by suicide and those who provide services to them. [28]

7.22 A wide range of other potential research areas were identified by SPA during community consultations including: the impact on professionals of suicide by patients; vicarious trauma on first responders and others who work closely with suicide; evaluations of completed suicide by persons refused admission to psychiatric care and following hospital discharge; practices of detention and seclusion within mental health facilities; inadequacies in assessment and response to people at risk of suicide; effectiveness of anti-depressants in suicide prevention; use of new media and internet in suicide prevention; impact of global wide scale events such as the global financial crisis; and the relationship between economic disadvantage and suicide.[29]

7.23 AISRP proposed two specific research projects. The first a study to assess the effectiveness of intensive case management on outcomes for suicidal psychiatric patients in the post discharge period. The second was a model of treatment for suicidal behaviour which offers an alternative to hospital-based care. The aim of the 'Life House' project is to develop an alternative to hospital-based care that can provide a comprehensive range of services (including community based psycho-social rehabilitation) for individuals who are suicidal.[30]

Funding

7.24 Funding for research and evaluation of suicide prevention activities was identified as coming from two sources. The first was Commonwealth, State and Territory health departments which provide resources for internal or external evaluation of particular suicide prevention activities they have funded. Associate Professor Jane Pirkis commented:

> Contracts awarded by health departments provide for evaluations of a range of often large and complex initiatives, but the evaluations tend to be constrained (e.g., the intervention is often well under way by the time the evaluation is commissioned, making it difficult to gather baseline information).[31]

7.25 The second source of research funding was academic granting bodies such as the NHMRC and the Australian Research Council (ARC). Associate Professor Jane Pirkis stated that grants from these organisations are '…investigator-driven and peer reviewed, so they are typically very strong methodologically, but the funding is usually limited so the interventions they test tend to be fairly small in scale'.[32]

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28 SPA, *Submission 121*, pp 61-62.

29 SPA, *Submission 121*, p. 62.

30 AISRP, *Submission 237*, pp 210 – 214.

31 Centre for Rural and Remote Mental Health Queensland, *Submission 27*, p. 3.

32 Associate Professor Jane Pirkis, *Submission 27*, p. 3.

7.26 Prior to 2006 the scope of the NSPP did not allow funding of research projects. DoHA commented that while 'the capacity for funding research directly through the NSPP is limited, there are other sources of funding available to support research into suicide prevention and related areas'. DoHA provided a table summarising NHMRC funding of mental health, suicide and substance abuse. This table indicated that the NHMRC research funding for suicide has fluctuated but had not increased at the same level as research for mental health and substance abuse. NHMRC mental health research funding had steadily increased from $7.5 million in 2000-01 to $28.9 million in 2006-07. In contrast, funding for suicide research was $0.96 million in 2000-01 and had fallen to $0.58 million by 2006-07.[33]

7.27 The Australasian Society for Psychiatric Research analysed previous NHMRC research grants to determine the relative proportion of NHMRC funding provided for research focusing on suicide prevention strategies. In 2010 they found no NHMRC research grants for suicide prevention research and little funding in previous years had been directed to suicide and its prevention (in either project grants or fellowships). They recommended priority funding be set aside for suicide in subsequent NHMRC rounds.[34]

7.28 RANZCP also highlighted that the NHMRC research expenditure on the issue of suicide was considerably less than other social problems and diseases with similar mortality rates such as breast cancer, skin cancer and road traffic accidents.[35] They recommended better collaboration between Commonwealth and State governments to fund research into suicide prevention and the appointment of an expert body to oversee all suicide prevention research linked to academic institutions. [36]

7.29 Professor Joan Ozanne-Smith commented that the current focus of research, research funding and organisational committees and their structures is on mental health. She noted '…people taking a different perspective have been excluded from some of these national processes'.[37] Dr Erminia Colucci also sought to bring the lack of specific funding for suicide research to the attention of the Committee. She noted that suicide researchers such as herself must apply for general mental health, community and health promotion grants which give them '…little chance to ever get our hands on these grants because other topics are usually favoured'.[38]

7.30 Other witnesses commented on the lack of funding for research centres for suicide. Mr Sebastian Rosenberg from the BMRI contrasted the resources available for alcohol and drug research to those available to research suicide:

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33 DoHA, *Submission 202*, p. 67.

34 Australasian Society for Psychiatric Research, *Submission 20*, pp 1-2.

35 RANZCP, *Submission 47*, p. 11.

36 RANZCP, *Submission 47*, p. 23.

37 Professor Joan Ozanne-Smith, NCIS, *Committee Hansard*, 4 March 2010, p. 48

38 Dr Erminia Colucci, *Submission 77*, p. 1.

> …when it comes to comparing and contrasting developments in the alcohol and drug sector, is this purposive investment in independent research centres which are able to operate as an engine to gather and validate information to inform public debate and to inform, frankly, public spending. That makes a huge difference to being able to make astute decisions about what works and what does not work in alcohol and drugs.[39]

7.31 Mr David Crosbie of the MHCA contrasted the federal funding of research centres in relation to drugs and addiction. He stated:

> We have a real lack of a bringing together of the researchers who are trying to do work in this area and creating the kinds of economies of scale and the kind of capacity that is needed to actually say what is happening in mental health in this country at the moment.[40]

Conclusion

7.32 A consistent message that the Committee received during the inquiry was that there is limited evidence regarding which suicide prevention interventions are effective and consequently there is an urgent need for research in this area. However many submissions and witnesses also acknowledged that the evaluation of suicide prevention activities could be difficult and costly.

7.33 There does appear to be potential for Commonwealth, State and Territory governments, together with national research funding organisations, academic institutions and other organisations to cooperatively fund detailed evaluations of suicide prevention interventions. However these opportunities to pool funding for important research ultimately depend on the willingness of funding partners to participate.

7.34 The Committee considers a simpler approach would be to include funding in the NSPP for major evaluations of suicide prevention interventions. This would have the potential of allowing these large scale assessments to be tied into the individual project evaluations requirements which already exist for many projects funded under the NSPP.

Recommendation 35

7.35 The Committee recommends that the Commonwealth government provide funding in the National Suicide Prevention Program for research projects into suicide prevention, including detailed evaluations of suicide prevention intervention.

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39 Mr Sebastian Rosenberg, BMRI, *Committee Hansard*, 1March 2010, p. 57.

40 Mr David Crosbie, MHCA, *Committee Hansard*, 1 March 2010, pp 22 – 23.

7.36 There was general agreement that the LIFE suite of resources and materials were valuable for both suicide prevention researchers and service providers. However some service providers and community organisations who worked 'at the coalface' did not feel that research was being disseminated to them appropriately.

7.37 The Committee considers there is scope for the organisations which collect and distribute suicide research in Australia to be more proactive in both identifying research findings and then locating organisations and staff who may benefit from that research. These organisations include: the Life Communications project responsible for the LIFE suite of resources; the NCESP which publishes the bi-annual suicide prevention literature review; SPA which regularly creates position statements on aspects of suicide prevention; and the ABS and NCIS which collect and record suicide statistics.

7.38 The Committee supports the Lifeline Australia recommendation for the creation of a suicide prevention resource centre and best practice registry. In particular the Committee considers the sector would benefit from a research centre which would:

- function as source of reliable information for those seeking suicide prevention services such as training;
- identify and list evidence-based suicide prevention practices and programs, including community programs, training and service delivery;
- offer guidance to people seeking to develop and implement best practice activities;
- operate as a clearing house for collecting, listing and accessing standards that meet professional consensus-based criteria for best practice;
- provide a forum where practitioners and researchers can communicate and develop best practice in suicide prevention; and
- provide a forum for progressing research priorities in suicide prevention.[41]

Recommendation 36

7.39 The Committee recommends the Commonwealth government, as part of the National Suicide Prevention Strategy, create a suicide prevention resource centre to collect and disseminate research and best practice regarding suicide prevention.

41 Lifeline Australia, *Submission 129*, p. 68.