

## Recent trends in rural suicide and community-based suicide prevention in rural areas

**Michael Dudley**, Suicide Prevention Australia, **Martin Harris**, School of Rural Health, University of Tasmania, and SPA Tasmanian delegate, **Lucy Henry**, CommunityLIFE project, Curtin University of Technology, WA

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This paper reports recent trends in rural suicide, then gives an account of recent thinking about community-based suicide prevention programs, making special mention of rural areas and the CommunityLIFE program. The talk does not specifically address responses to individual situations of clinical risk.

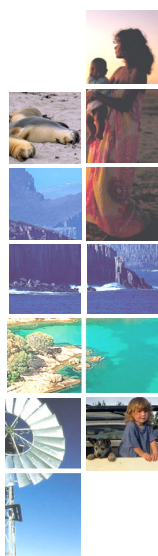
### SUICIDE PREVENTION AUSTRALIA

Suicide Prevention Australia (SPA) is a member organisation founded in 1992. It has approximately 300 individual and corporate members. Its charter is to prevent suicide in Australia, using community-based education and training, advocacy, and networking of governments, organisations and individuals to achieve this goal. Its annual conference provides premier opportunities for these activities. SPA has historically always been concerned with rural areas, through its training programs and its research focus. It has had close links with the NRHA for some years, in working on community-based suicide prevention.

### RECENT TRENDS IN RURAL SUICIDE, AND REASONS

For approximately the last 15 years, a series of expert reports and news stories have made Australians aware that they have been experiencing rising male youth suicide rates. One 1998 report indicated that from 1990–1994, Australia had the fourth highest recorded male youth rate and the eighth highest female youth rate in the world. Male 15–24 year rates fell in 1999 and 2000, but the above trends have also affected young males aged 25–34 years, whose rate of 33 per 100,000 in 2000 made them the age and sex group at highest risk [Australian Bureau of Statistics, 2001].

The resultant broad-based community concern was expressed in the Commonwealth Government's National Youth Suicide Prevention Strategy (NYSPTS) (1995–1999). This provided the umbrella for a series of national, state and local prevention initiatives, both government and non-government based. Recent reports have drawn attention to the fact that suicide trends affect not only youth (aged 15–24 years), but young adults (aged 25–34 years), and that rates among the very old, though falling and based on



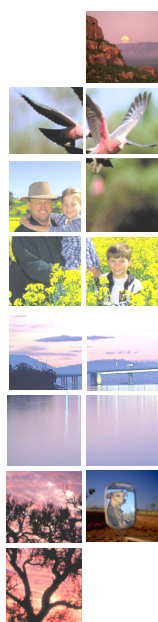
small numbers, are still among the highest [Australian Bureau of Statistics, 2001]. The Commonwealth Government's new LIFE program, which supersedes NYSPS, reflects these findings, and is oriented for all age groups.

Male youth suicide in Australia predominates in rural compared with non-rural areas, and male youth suicide rates in small rural towns and remote areas are up to double those in metropolitan areas. Colleagues and I found rates for 15–24 year metropolitan males more than doubled from 1964–1998, but increased more than tenfold for males from small towns. Substantial numbers in the latter settings indicated that these trends were not artefacts of small numbers. While male hanging rates greatly increased in metropolitan and rural areas, firearm rates rose in small rural areas throughout this period and were much higher in those areas than in metropolitan areas. Female rates did not change overall in Australia during this time, but substantially increased in small towns over this period. Indigenous male youth suicide rates in remote communities in 1994–1998 were up to three times those in metropolitan settings. However, these trends are not uniform around Australia [Dudley et al, 1998; Dudley, unpublished data].

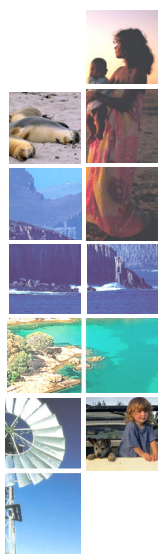
The reasons for these trends are controversial. It is not clear to what extent coroners have been more willing in recent years to reach verdicts of suicide, but it seems unlikely that any such changes would substantially account for such trends. In general, risk factors for youth suicide and attempted suicide include mental health, child and family, and socioeconomic problems. Mental health problems are common among youth, with some studies indicating that 20–25% of adolescents suffer or have suffered from them. In particular, past suicide attempts, a history of previous psychiatric care, mood disorders (including depression), substance misuse, antisocial behaviour and multiple diagnoses are highly significant as risk factors. However, they also reflect the endpoint of continuing adverse environments, lack of valued social roles and disrupted personal histories. Some social and historical factors, such as low socio-economic status, poor educational achievement, childhood abuse, and family history of suicidal behaviour, have a proven relationship to individual risk. Researchers have noted that other possible factors, which are harder to test, have affected successive cohorts of young people: increasing rates of parental separation and repartnering, increasing psychological ill-health among youth, the decline of organised religious observance, and a consumerist culture that fails to generate hope [Beautrais, 1998 & 2000; Eckersley, 2002; Patience, 1993].

These risk factors, which are generally noted with suicide and suicidal behaviour among Australian and overseas youth, may also be relevant for rural youth suicide. However, the differences in rural and metropolitan youth suicide rates require other explanations, which relate to factors as diverse as economics and health on the one hand, and cultural identity and gender roles on the other.

Rising rates in small rural towns in part reflect industry closures, loss of local resources and youth population migration to larger rural centres. Those left behind or moving in may be most vulnerable. Rural youth have less access to socioeconomic, health and educational resources than non-rural youth, and health indices in particular reflect this disparity of resources. Some authors have presented evidence that from metropolitan to rural to remote areas, mortality and morbidity rates increase for injuries, poisonings, accidents, interpersonal violence, and nearly all major disease categories [Titulaer, in Gregory and Murray, 1997]. Whether this gradient also



includes the prevalence and severity of mental health problems is uncertain. Health service access and utilisation (including mental health services) and healthy behaviours, such as lower alcohol consumption, not smoking and walking for exercise, decline in similar fashion. Lack of experienced practitioners, confidential counselling and health information are also likely to be important. Young rural men may be constrained from using health services by traditional sex roles and attitudes. These include the belief that men should “tough it out”, and not talk about feelings or seek help, because this is seen as a sign of weakness. Problems with sexual orientation may be undiscussable in some rural towns. Young women may be inhibited from help-seeking by the dearth of women doctors in rural communities. Rural youth also have more access to guns. Indigenous youth and communities, especially in rural and remote areas, are disadvantaged through a vast range of historical, cultural, socioeconomic and health factors. No research has yet occurred, however, to systematically determine which of the problems experienced by many rural youth are also related to suicidality.



## COMMUNITY DEVELOPMENT, CAPACITY BUILDING, AND SOCIAL CAPITAL

The term “community” usually refers to a group of people living in a geographical area, or people who share an ethnic, cultural or religious affiliation, or people who are linked through a particular interest or circumstance e.g. as members of community organisations.

Community development is community building its capacity to protect and enhance the health and well-being of its members. A key principle is that of community ownership. Communities are more committed to change that is driven from within. This involves community groups becoming aware of a problem, developing a shared understanding that it needs to be addressed, and making a commitment to address the problem and begin to work together to seek solutions. Outsiders may be invited to participate as a part of this process. Although some community programs assume that the importance of a particular issue is under-recognised and needs to be actively promoted, it is often difficult to create a long-term commitment when the community concerned has not previously identified the issue as a priority. Community development literature suggests that it is better to go with issues that communities have identified as priorities.

Community development activities generally build organisations or structures that represent a wide cross section of the population – particularly those who may find it difficult to gain access to or be heard in community development processes. The community in a democratic fashion must control these structures. Such activities should support the participation of young people. They should build formal links between local communities and existing local, regional, state/territory and national planners, funders and governments, and provide professionals and community members with training in skills relevant to community development.

Community development, particularly in relation to youth suicide prevention, is a strategy for mending breakdowns in the social fabric of a community. Providing a space where young people can gather, spend time and feel they belong is very important for engaging marginalised young people in community development



activities. Including young people in consultation and ongoing decision-making processes is vital to their engagement.

Community capacity can be defined as “characteristics of communities that affect their ability to identify, mobilise and address social and public health problems” and “the cultivation and use of transferable knowledge, skills, systems and resources that affect community – and individual-level changes consistent with public health-related goals and objectives” [Goodman et al, 1998]. Capacity operates at the individual, group, organisational, community and policy levels. It is both process and outcome. Its key components include participation and leadership, skills, resources, social and inter-agency networks, sense of community, community history, community power, community values and critical thinking [Goodman et al, 1998].

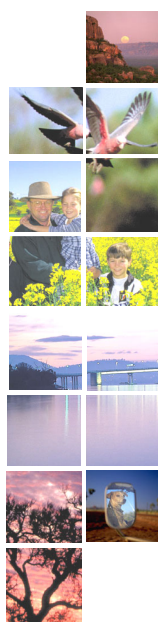
Social capital, a closely related concept to community capacity, has been defined as the “fabric that binds society together” – the networks, trust and reciprocity that exist between individuals and/or groups within a community. It includes aspects such as cohesion, co-operation, values, ability, motivation, and physical and social structures. It is both local and general, and it has a key relationship to the health and well-being of individuals and community. Social capital and rural communities’ (mental) health include factors such as geography and environment, history and cultural traditions, local, national and international economies, gender, information technology, and Indigenous peoples and communities, among many others.

Capacity-building leadership is diverse. It includes formal and informal leaders, encourages participation from a diverse range of players, ensures democratic decision-making and effective planning, nurtures and supports new leaders. Leadership and participation go hand in hand. Effective leadership will be characterised by the skills to conduct a needs assessment and plan, to collect and analyse data about problems, opportunities, barriers and resources, to solve problems, to resolve conflict, and to advocate.

Community values/spirituality may include the aim to enhance health and well-being, having democratic processes to reach agreement about values and visions, and shared beliefs, traditions, meanings and goals. The relation of community values/spirituality to community power is complex, however. Power is often unequally distributed across neighbourhoods and groups within communities, and it may be reflected in how much social capital is present in the community and how this is used to create or resist change that matters to people.

## PRINCIPLES OF EFFECTIVE COMMUNITY-BASED SUICIDE PREVENTION

Suicide prevention is about preventing suicide and promoting mental health and resilience among people in our community. It is a clinical (or related) intervention, a population intervention or initiative, a scientific or social scientific body of research, practice and theory, and a community movement. Suicide is a complex problem that is thought to result from the build up of risk factors that relate to problems and concerns across our society. Effective action to prevent suicide therefore should encompass a wide range of activities across a number of programs and sectors. It requires the effort of the whole Australian community including community groups, families and young



people, all levels of government, business and non-government and professional organisations. There is some evidence that such national “whole-of-community” programs can be effective, as the Finnish and Australian experiences show [Australian Institute of Family Studies and Commonwealth of Australia, 2000].

The principles of effective suicide prevention include shared responsibility across the community, professional groups, government and non-government agencies; a diverse approach targeting the whole population, specific population subgroups and people at risk; and evidence-based programs, focusing on results, with evaluation as an integral part. Effective suicide prevention programs must incorporate input from the community, carers and experts, and must be sustainable to ensure a continuous and consistent service.

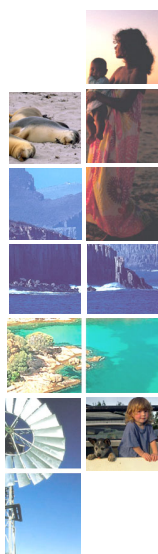
It is crucial that such activities do no harm. Some well-meaning activities that aim to prevent suicide can increase risk of suicide among vulnerable groups. It is particularly important to keep this in mind in programs involving schools, the media or raising awareness of suicide. All approaches need to be pilot tested and carefully evaluated for negative as well as positive outcomes.

A range of considerations applies to the planning of suicide prevention activities for communities. Activities may range from community-wide prevention to crisis response or risk management, and the target group may be the whole population or high-risk groups or individuals. Evidence for the efficacy of the approach should be noted; even where evidence is limited, the likely costs and benefits of the strategy should be apparent, and activities should be able to show they reduce the level of risk. The place and role of the activities in the overall field of suicide prevention should be clear – including its nature, potential scope, boundaries and limitations. A collaborative approach including relating to others provides a more integrated and effective approach.

In selecting an approach one considers not only how strong a risk factor is in a particular group in the community but also how common it is. Activities that focus on a risk factor that places an individual at high risk may have a smaller effect on overall suicide rates than a program that focuses on a lower-risk but relatively common risk factor.

## COMMUNITY-BASED SUICIDE PREVENTION IN THE AUSTRALIAN CONTEXT

The NYSPS responded to the cultural complexity of suicide with an ambitious agenda, ranging from preventing the risks for suicidal behaviours to dealing with the aftermath of suicide. Primary prevention programs for parents, the media, schools and communities, targeted known suicide risk factors and sought to enhance youth resilience. Early intervention and crisis intervention programs aimed to improve access to and quality of the telephone counselling, hospital casualty and primary health services for suicidal youth, and to educate youth in crisis intervention and accessing services. Increasing the availability of counselling for young people in rural and remote areas was part of this component. New treatment programs for marginalised young people (e.g. those who are homeless, involved with the justice and juvenile justice systems, or who have sexual identity issues) and those with mental



disorders (especially depression, psychosis, and substance misuse) were funded. Efforts were made to reduce access to methods. Postvention after suicide was flagged as an important area for further work. There was also a recognition that changing the response to youth suicide at a system level requires better research evidence, better educational resources and programs, better collaboration between different bodies involved with youth, and better attention to cultural difference. It was acknowledged that the latter involves special attention to the needs of Indigenous, non-English speaking and rural and remote communities (Australian Institute of Family Studies and Commonwealth of Australia, 2000).

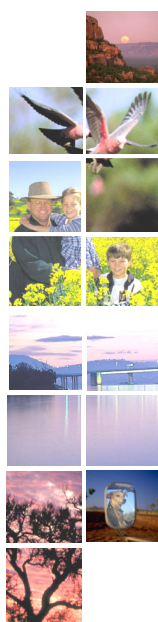
In rural areas, various projects have been trialled. Some have focused more directly on target groups, while others have worked more indirectly via education, service development and networking, developing good policies and protocols, promoting positive images of youth, advocacy, and reducing access to methods. The community development focus has been strong in rural areas. The LIFE program aims to improve suicide prevention information and resources to rural and remote communities, to develop, pilot and evaluate suicide prevention models suitable for a range of such communities, and to trial one such model in at least one rural region. Particular attention is given to the needs of young men, and their engagement with services. Partnerships with Aboriginal and Torres Strait Islander peoples form a major plank in the new agenda, and this is a core part of the CommunityLIFE program (see below).

## ONE SUCCESS STORY

While community-based suicide prevention programs are still in their infancy in Australia and overseas, one example of a success story in community development and suicide prevention is the story of Yarrabah aboriginal community [Hunter et al, 1999]. Yarrabah was founded in the 1890s as an Aboriginal mission. It was administered by the diocese of North Queensland, and then by the Queensland government. Infrastructure, services and formal community self-management did not occur till the mid 1980s. The community identified problems of violence, racism, cultural dislocation, permanent unemployment, poverty and lack of basic amenities, alcohol and drug misuse, inseparable from decades of marginalisation of Aboriginal people in general. Suicide did not become a common occurrence till mid 1980s, after which there were 3 “waves” of suicides.

Community ownership of problem of suicide and the response to it was crucial in the subsequent success of the strategy. This involved democratic, community controlled decision making, a social-historical understanding of health, a primary health care approach, a focus on community rather than individual risk, and the development of knowledge and skills over time.

Following an initial phase of shock, confusion, despair and resignation, a stage of commitment to working on the problem and collaboration was reached as a result of community meetings. While community development was always driven by locals, initial approaches focused on underlying causes, individual risk and involved outside expertise. The latter included the Royal Commission into Aboriginal Deaths in Custody, the visiting psychiatric service, a research project of James Cook University (after 1st wave of suicides), and suicide prevention training by external experts (after 2nd wave). A community Council meeting at beginning of the third wave began



community mobilisation, and a family Life Promotion Program began. Shutting down the alcohol canteen was a significant measure in the community taking control of its own issues and self-direction.

In sum, the factors that enabled the achievements were community ownership of the problem and the solution, appropriate resources and support. This enabled a structured program and protocols to be put in place, and ongoing needs assessment and planning (not just crisis responses). Comprehensive, community controlled primary health care services enabled a range of culturally appropriate interventions to be put in place.

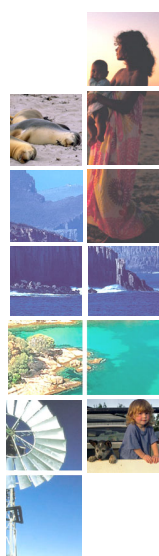
## THE COMMUNITYLIFE PROGRAM

The CommunityLIFE Program is funded by the Federal Department of Health and Ageing. It aims to build community capacity for suicide prevention. It is based on the LIFE Framework, the national framework for suicide prevention in Australia, and has a mainstream and an Indigenous component. It is managed by a consortium, comprising at this stage, the Centre for Developmental Health (CDH) based in Perth, Auseinet based in Adelaide, and Suicide Prevention Australia (SPA) based in Sydney. Discussions are occurring with a view to the National Aboriginal Community Controlled Health Organisation (NACCHO), based in Canberra, also joining the consortium.

The *LIFE Framework* document promotes a collaborative approach, involving government and non-government services, community groups, and individuals. It aims to reduce the incidence of suicide and enhance resilience and resourcefulness, and to increase support available to individuals, families and communities affected by suicide or suicidal behaviours. It provides a whole of community approach to suicide prevention and to extend and enhance public understanding of suicide and its causes.

CommunityLIFE aims to help meet community need for suicide prevention programs consistent with the National Suicide Prevention Strategy *LIFE Framework*. It will build partnerships with key non-Indigenous and Indigenous groups to enable the growth and diffusion of good practice suicide prevention activities. It will enhance community participation, capacity building and skills in planning, implementing and evaluating safe, effective and sustainable community suicide prevention programs. A key outcome will be knowledge development to inform the Commonwealth and the nation.

It will not be known for some years whether NYSPS and its successor, LIFE, have made a difference to suicide rates, risk factors or resilience at a population level. However, tentative evidence has accumulated from evaluation that significant gains were made by NYSPS. This is despite the short time since initiation of the Strategy, problems with using suicide rates as outcome measure, the absence of measurable intermediate objectives and lack of baseline and population data. A substantial minority of projects demonstrated positive impacts on individual and environmental risk and protective factors. Significant reductions in disability occurred for youth attending mental health services. Access, engagement and capacity-building emerged as major themes [Australian Institute of Family Studies and Commonwealth of Australia, 2000]. Male suicide rates for the year 2000 fell in all age groups, except 25-34 years [Australian Bureau of Statistics, 2001]. While it is impossible to prove that this



was due to the strategy, lower rates for two years in succession may signify that the strategy is working. There is still much to be learnt about community-based suicide prevention, especially in rural areas: 44% of respondents believed that there had been no change in the availability of counselling for young people in rural and remote areas between 1995 and 1999. Thus, this is a story about collaboration and partnerships, with some indications about success.

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