



THE UNIVERSITY OF  
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# **Suicide Prevention Research and Campaign: Integrated findings and recommendations**

**Angela Nicholas, Jane Pirkis, Alyssia Rossetto,  
Anthony Jorm, Jo Robinson, Nicola Reavley**

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## Executive Summary

In 2015, 3,027 Australians died by suicide, representing a steady increase over the preceding decade.<sup>1</sup> This upward trajectory has caused considerable community concern, and efforts to identify effective suicide prevention interventions have received increasing attention. A significant proportion of people who die by suicide are not in contact with mental health or general health services.<sup>2-4</sup> Rather, research evidence suggests that people at risk of suicide often communicate their suicidal thoughts and intentions to family members and friends before they make a suicide attempt.<sup>4-7</sup> Therefore, there may be an important role for family members and friends in identifying and intervening in response to suicide risk. However, because family members and friends are frequently uncertain about how best to interpret and respond to this communication, they may be unsure about whether, or how, to address this suicide risk, and their responses may be unintentionally unhelpful or dismissive.<sup>5,8,9</sup> A suicide prevention campaign aimed at promoting identification of people at risk of suicide and positive helping responses among family members and friends could therefore have significant positive effects for both those at risk and those wanting to offer support who are unclear about how to do so.

In 2016, *beyondblue* funded the University of Melbourne's Centre for Mental Health and Where-to Research-Based Consulting to conduct research with the primary aims of understanding what evidence-informed and socially acceptable advice *beyondblue* could give the general public to increase the likelihood that they will ask about and support someone who may be at risk of suicide to stay safe and get the help they need; and to develop a communications framework for a future multi-media awareness campaign using the above formative research findings and recommendations. The research consisted of five components: (1) three literature reviews;<sup>10-12</sup> (2) an expert consensus study;<sup>13</sup> (3) a qualitative research component involving focus groups and interviews;<sup>14</sup> (4) an online questionnaire study;<sup>15</sup> and (5) a nationally representative computer-assisted telephone survey.<sup>16</sup>

Our research findings suggest that Australian adults generally have positive attitudes to suicide prevention and are confident to support someone they know well who is in severe distress or at risk of suicide. Most commonly, they offer assistance that those at risk find helpful by listening and talking to them, offering them support, and encouraging them to seek professional help. Most of our research participants who had experienced suicide risk were able to identify someone who had been helpful to them when they were at risk. These results are encouraging, suggesting a widespread willingness to help family members and friends in distress or at risk of suicide, and that they are taking appropriate steps to do so. However, our research also showed actions to assess level of suicide risk and help ensure the safety of the person at risk were far less common than general supportive behaviours. These actions include asking questions about suicidal thoughts, plans and means, and removing means. Men were less likely than women to ask direct questions about suicide risk and to take steps to ensure the safety of a person at risk. People aged 60 or older were also less likely than younger people to ask whether someone was thinking about killing themselves. Only about half of participants in the national telephone survey intended to take steps like asking questions about suicidal thoughts, plans and means, and removing means, even when the person verbally expressed suicidal intentions. Since the results of our online questionnaire study, and other previous research studies have shown that only a minority of people express their suicide risk verbally and directly to others, it is important that community members are able to identify non-

verbal signs of suicide and assess suicide risk. Qualitative study participants expressed doubt in their own ability to identify when someone was at risk of suicide, and particularly how the signs might differ from someone experiencing sadness in response to life events. Qualitative study participants also expressed a desire for clear guidance on how to approach a person they were concerned about, how to ask direct questions about suicide, and the steps to take to help them.

Our national survey showed that attitudes to suicide prevention were generally positive and that helping intentions and behaviours toward someone in severe distress or at risk of suicide were generally appropriate. However, we did identify some areas for which knowledge and attitudes could be improved; for example, almost 50% of participants believed that helping a person at risk of suicide requires the skill of a professional, about 40% of respondents believed that suicide happens without warning, and about 30% believed that most suicides occur without any sign, that asking someone about suicide could make them start thinking about it, or trying to help someone at risk could make the situation worse. These attitudes have the potential to reduce confidence and inhibit potentially helpful behaviours towards a person at risk. Both the national telephone survey and the online questionnaire study also explored the frequency of non-recommended actions, including reminding people who are considering suicide 'what they've got going for them', telling them how much their suicide would hurt their friends and family, and trying to convince them that suicide is wrong. These actions were commonly reported by respondents who had experience suicidal ideation and who had a close friend or family member at risk of suicide. In addition, participants from the two survey studies who had been at risk of suicide identified helper responses that minimised their thoughts and feelings or indicated that the helper did not consider their mental health difficulties to be 'real' as the most unhelpful types of response. Our expert consensus study also showed that experts believed that promotion of the message 'take all talk of suicide seriously and do not dismiss it as attention seeking or a 'cry for help' to be imperative to a suicide prevention campaign.

## **Recommendations for a suicide prevention campaign**

Our research findings show some areas for potential improvement in relation to Australian adults' knowledge, attitudes, confidence, intentions and behaviours related to suicide prevention. Based on the key findings of this research, we have made a number of recommendations about possible inclusions in a suicide prevention campaign aimed at family members and friends of a person in severe distress or at risk of suicide. These are outlined below.

Such a campaign could include messages that communicate:

- that non-professionals can be of great assistance to people at risk of suicide, though assisting the person to seek professional help is also encouraged;
- that non-professionals can seek information and training to improve their own ability to assist in an appropriate way;
- that trying to assist, or asking or talking about suicide to, someone who is having thoughts of suicide will not increase the likelihood that they will attempt suicide;
- that all talk of suicide should be taken seriously and not dismissed as attention seeking, a 'cry for help', or 'not real' because it relates to mental health difficulties;

- that those wanting to support someone at risk of suicide can seek professional support to do so and don't need to 'go it alone';
- how family members and friends wanting to help a person at risk can access appropriate supports, particularly if a suicidal person is resistant to being helped or the helper feels that they are not equipped to help the person in distress, but wants to ensure the person at risk gains assistance;
- how to identify when someone is at risk of suicide, especially in relation to non-verbal indicators of risk such as behavioural changes like uncharacteristic reckless behaviour, increased drug or alcohol use, social withdrawal, agitation, insomnia, or dramatic changes in mood; and indirect verbal communications such as expressions of hopelessness, purposelessness or of being trapped with no way out;
- that family members should tell the person they care and want to help;
- that family members and friends can ask direct questions about thoughts, plans and means of suicide in order to assess the urgency of suicide risk;
- that family and friends should take direct actions to promote the immediate safety of someone at risk where imminent risk is identified, such as by calling a crisis line for advice and removing means where they have been accumulated;
- that family and friends can help the person to get assistance from a health or mental health professional or call a suicide help line as soon as possible;
- educational messages about what not to do, including reminding people who are considering suicide 'what they've got going for them', telling them how much their suicide would hurt their friends and family, and trying to convince them that suicide is wrong.

In addition:

- targeting men, people aged over 60 years and people who speak a language other than English at home to increase their confidence in talking about suicide could be valuable;
- targeting men and people aged over 60 years to increase their intentions to carry out helpful rather than unhelpful actions and to encourage them to ask direct questions about suicide risk and take appropriate action to ensure the person's safety could also be beneficial.

## Background

In 2015, 3,027 Australians died by suicide, representing a steady increase over the preceding decade.<sup>1</sup> This upward trajectory has caused considerable community concern, and efforts to identify effective suicide prevention interventions have received increasing attention. One intervention gaining increasing international attention is the suicide prevention media campaign. Although international evidence for the effectiveness of such campaigns is mixed, there are suggestions they can change attitudes, intentions and behaviours relating to suicide.<sup>17</sup> The evidence regarding the effective elements of suicide prevention media campaigns, however, requires further development.<sup>17</sup> It is imperative that any suicide prevention campaign include acceptable and appropriate messaging that is evidence based and does no harm.<sup>18</sup>

A significant proportion of people who die by suicide are not in contact with mental health or general health services.<sup>2-4</sup> Research evidence suggests that people at risk of suicide often communicate their suicidal thoughts and intentions to family members and friends before they make a suicide attempt.<sup>4-7</sup> Therefore, there may be an important role for family members and friends in identifying and intervening in response to suicide risk. However, because family members and friends are frequently uncertain about how best to interpret and respond to this communication, they may be unsure about whether, or how, to address this suicide risk, and their responses may be unintentionally unhelpful or dismissive.<sup>5,8,9</sup> A suicide prevention campaign aimed at promoting identification of people at risk of suicide and positive helping responses could therefore have significant positive effects for both those at risk and those wanting to offer support who are unclear about how to do so.

In 2016, *beyondblue* funded the University of Melbourne's Centre for Mental Health, in partnership with *Whereto* Research-Based Consulting to conduct a series of research components with two primary aims:

1. Conduct formative research to answer the question: What evidence-informed and socially acceptable advice can *beyondblue* give the general public to increase the likelihood that they will ask about and support someone who may be at risk of suicide to stay safe and get the help they need?
2. Develop a Communications Framework for a future multi-media awareness campaign using the above formative research findings and recommendations.

The research conducted consisted of five components: (1) three literature reviews;<sup>10-12</sup> (2) an expert consensus study;<sup>13</sup> (3) a qualitative research component involving focus groups and interviews;<sup>14</sup> (4) an online questionnaire study;<sup>15</sup> and (5) a nationally representative computer-assisted telephone survey.<sup>16</sup>

This report summarises and integrates the findings of all five research components and makes recommendations to *beyondblue* regarding the development of a suicide prevention campaign aimed at the general public and particularly family members and friends of people at risk of suicide. This report is supported by a communications framework, prepared by *Whereto*, that provides practical suggestions arising from the research findings that can be translated into a suicide prevention campaign brief.

## Our research

### Literature Reviews

#### **i. Identifying, approaching and supporting someone at risk of suicide: What community members know, believe and do.**

The aim of the first literature review was to identify what is known about current community knowledge, attitudes, confidence, capabilities, intentions, and behaviours in relation to identifying, approaching and supporting someone at risk of suicide, and knowing how to ensure their safety, and how these variables can best be measured. We searched Medline, PsycINFO and Scopus databases for relevant peer-reviewed literature, published between 2006 and 2016 in English. We identified eighty-one papers covering these topics, and a further 38 papers reporting data on a control group or baseline survey prior to the delivery of a suicide intervention program.

The findings suggest that, in general, community members have a good knowledge of suicide signs and symptoms, available sources of help and treatment, and what to do when a person discloses thoughts of suicide. However, they could be very reluctant to speak openly about suicide and put their knowledge and skills into practice when faced with a loved one experiencing suicidal ideation. In particular, males and people from culturally and linguistically diverse backgrounds were less knowledgeable and skilled in identifying, approaching and supporting someone at risk of suicide.

#### **ii. Interventions that empower family members and friends to play a role in keeping someone at risk of suicide safe**

The second literature review aimed to identify what is known about interventions that empower family and friends to play a role in keeping someone at risk of suicide safe, particularly the safety planning intervention. We searched Medline, PsycINFO and Scopus for relevant literature published between 2006 and 2016 in English. We included peer-reviewed papers that examined brief interventions or training; were aimed specifically at family members, friends or peers of people at risk; and assessed the effectiveness of these interventions. We excluded longer-term interventions and those aimed primarily at the person at risk. From this search, we identified four broad types of relevant interventions: (1) universal school-based programs (10 studies of seven programs); peer-gatekeeper training programs (six studies of five programs); (3) brief family interventions for caregivers of at-risk individuals (five studies of four interventions); and (4) safety planning involving family members (three studies of the one intervention).

We found that universal school-based programs and university-based gatekeeper training commonly included similar training components. These covered warning signs for suicide, steps for helping a peer at risk of suicide, taking responsibility for asking about suicidal thoughts, and helping a peer to seek help from a trusted adult. University programs also included training to improve skills in talking to someone about their suicidal thoughts, then directly helping them to access support through local resources. The majority of these programs showed immediate positive effects on the knowledge, intentions and confidence of participants in identifying someone at risk of suicide and offering assistance. There was little evaluation of longer-term effects. The brief family-based interventions most commonly included listening and communication skills training for family members. Only one study assessed and then reported reductions in suicidal ideation and threats following intervention, evidenced at nine-month follow-up. Interventions following a suicide event that involved safety

planning and telephone follow-up with the person at risk and their family showed positive effects on engaging the person at risk in outpatient mental health services. However, there was little evidence that such interventions had a positive effect on suicide behaviours.

### **iii. Suicide prevention media campaigns**

The third literature review was conducted with the aim of identifying what is known about mass media/multi-media awareness campaigns designed to prevent suicide, particularly those targeted to encourage the general public to play a role in suicide prevention, and how these can be best evaluated. We searched four electronic databases for studies that described an evaluation of the effectiveness of an entire campaign or community service announcement (CSA) and reported any outcomes that related to suicide (e.g., attitudes towards suicide, suicidal thoughts, suicidal behaviours, seeking help in a suicidal crisis, suicide). We considered studies of campaigns that were explicitly aimed at suicide prevention, and excluded studies of campaigns that were designed to raise awareness of depression or other mental illnesses.

We identified 15 studies of varying quality. Studies that looked at whether campaign exposure leads to improved knowledge and awareness of suicide found support for this. Most studies that considered whether campaign materials can achieve improvements in attitudes towards suicide also found this to be the case, although there were some exceptions. In regard to behavioural outcomes, some studies found that media campaigns boosted help-seeking, whereas others suggested that they made no difference or only had an impact when particular sources of help or particular types of help-seeking were considered. Relatively few studies had sufficient statistical power to examine whether media campaigns had an impact on suicide rates, but those that did demonstrated significant reductions.

## **Empirical studies**

We used a variety of methodologies and participant groups across the four empirical studies in order to develop guidance regarding the content of a suicide prevention campaign aimed at family members and friends of people at risk of suicide. The participants, methods and key findings from each study are outlined below. This program of research has a mixed methods design, using a variety of research methods to gain information from a variety of stakeholders in order to answer the overarching research questions. Each data collection method used has its strengths and limitations. Combining research methods allows researchers to capitalise on the advantages of each method. The limitations of each research method used are outlined in the following sections.

### **An expert consensus study**

We conducted an expert consensus study in order to identify messages that consumers with lived experience of suicide risk and suicide prevention professionals believe are most important to include in a suicide prevention media campaign. The study involved 127 members of blueVoices with experience of suicide risk and 33 suicide prevention professionals. blueVoices is 'beyondblue's reference group for people who have personal experience of anxiety, depression or suicide, or support someone who does'.<sup>19</sup> These participants rated 55 suicide prevention statements related to helping a person at risk of suicide from 'very low priority' (1) to 'very high priority' (5) for inclusion in a suicide prevention media campaign designed to increase the likelihood that the general



population, and particularly family members and friends, would appropriately identify and intervene with someone at risk of suicide. Participants also provided free-text responses regarding the statements and suggested additional statements missing from the pre-defined list.

Both participant groups most frequently rated as high priority for inclusion in a suicide prevention campaign the core message that family members and friends should *ask their loved one directly about suicide, listen carefully to the person at risk and show they care*. They differed, however, in that the suicide prevention professionals rated statements more highly that related to taking action, while the participants with experience of suicide risk rated more highly statements related to taking expressions of suicidal thoughts seriously.

This research methodology allowed us to draw on the expertise of both those with lived experience of suicide risk and suicide prevention professionals and to explore the similarities and differences in findings between these groups. However, because the sample for this study was highly targeted, being drawn specifically from the blueVoices group and from suicide prevention professionals mostly known to the researchers, care must be taken not to generalise the findings of this study to a more general population of people with experience of suicide risk and suicide prevention professionals in general. This sampling technique has the potential to bias the sample toward participants with particular points of view given their exposure to common sources of information related to suicide prevention. We also specifically asked participants to rate the importance of the statements for inclusion in 'a national media campaign for suicide prevention'. We recognise that this is a general statement and the results might not generalise to a campaign aimed at particular audiences. For example, the messages recommended for inclusion in a campaign aimed at helping young people at risk of suicide might differ from those recommended in our study.

### Qualitative research

Whereto Research-Based Consulting undertook a qualitative research component which involved a discussion with a range of people about their understanding of suicide and what they believe needs to be done to prevent it. Participants were 147 Australians recruited to represent a range of experiences related to suicide, including groups with no direct experience of suicide or suicide risk, and high-risk groups, people with current mild to moderate psychological distress, and those with personal experience of suicide. Participants took part in group discussions or in-depth interviews that were initially open and non-directive. They were then presented with a range of stimuli including newspaper articles, television advertising, online videos, print advertising and two lists of statements from the expert consensus study and discussed their reactions to different campaign strategies. One major advantage of conducting this type of qualitative research is the ability to gain in-depth insights into possible explanations for why people hold particular beliefs.

Findings from this research suggest that there was awareness and concern about high rates of suicide in Australia, especially for high-risk groups such as young men, Indigenous Australians, people living in rural areas. Participants struggled to understand the causes of the high rate of suicide, and believed that something needed to be done about it. They believed there is currently a lack of effective services and limited access to timely help. When asked to generate suicide prevention solutions, participants suggested better access to quality services (top priority); practical

community empowerment programs at work, school and university; strategies for building personal resilience, connectedness and community; shifting cultural barriers such as masculine norms that prevent men talking about their emotions and continuing open discussion about mental illness; talking more openly about suicide; and direct messaging to people at risk.

Participants were sensitive to the risks of such strategies, such as 'normalising' suicide. Although they did not suggest a campaign aimed at family and friends of people at risk of suicide among the above solutions, when they were asked directly about such a campaign they stated that it would need to clearly define the role of the public (what can I do?) and ensure the strategy would not exacerbate the problem.

A major barrier to community mobilisation was a fear of making things worse in approaching someone who might be at risk of suicide. Few participants knew how to identify someone at risk of suicide (compared with someone who is just 'quiet' or 'sad'), and how to approach them and ask direct questions about suicide. Participants advised against a campaign aimed at increasing awareness of Australia's high suicide rate. Rather, they wanted practical advice about what to do and how to do it, something akin to cardiopulmonary resuscitation (CPR) training, tailored to help people across the spectrum of suicide prevention from prevention, early intervention and crisis.

This type of qualitative research has many advantages, allowing researchers to gain detailed responses to the topics raised; to explore subtleties and complexities in participant responses; and to quickly revise their research framework to explore emerging trends that might not have been thought of when designing the research. However, because a convenience sampling method was used, in that participants were drawn from a database of potential research participants then screened, and the number of participants is relatively small, the findings cannot be considered to represent the population more generally. The findings should also not be generalised to the broader population sub-groups from which participants were drawn (e.g. Aboriginal and Torres Strait Islander people). Rather, these findings help to understand other research findings in greater depth.

### **Online questionnaire study**

Our third empirical study aimed to identify what helpful and unhelpful responses were offered to members of blueVoices<sup>19</sup> who had been at risk of suicide when they communicated that risk to others, and the types of help they wanted, but never received. One hundred and forty one blueVoices members completed an online questionnaire.

It was more common for respondents to have not communicated their suicide risk or to have communicated it in an indirect way. A large majority of respondents who said someone knew they were thinking about suicide were able to nominate a person who was helpful to them at that time. Of those nominated as the 'most helpful' person, about half were mental health professionals, and half non-professionals, mostly commonly a romantic partner or friend. Relative to the number of family members who were aware that a respondent was considering suicide, family members were the most frequently nominated 'most unhelpful' person. Listening without judgement and providing support were the two most frequently nominated 'most helpful' responses by others who knew the respondent was at risk of suicide. These were also the most frequently indicated helping actions that

were desired but never received. Responses that minimised the suicidal thoughts and feelings of the person at risk were the most commonly indicated 'most unhelpful' actions. Some 'non-recommended' responses to a person at risk of suicide (e.g., 'reminded you what you had going for you') were as commonly, or more commonly, carried out as some recommended actions that directly address suicide risk (e.g., 'asked you if you had a plan for suicide').

By including open-ended questions in this online survey, we were able to capture information about the helping experiences of those who had been at risk of suicide in a way it has not been previously been captured. Inclusion of the experiences of those who have lived experience of suicide risk is essential to the development of unique suicide prevention interventions. The recruitment method used for this study, however, included only members of blueVoices, who might not be typical of people in the community more generally who have a history of suicide risk; therefore, it important that these findings are not considered to be representative of this community more generally. This is especially true as our study sample had an elevated incidence of chronic or recurrent suicidal ideation and repeated suicide attempts, and therefore might have had different experiences to those who had a less chronic history of suicide risk.

### **Cross-sectional nationally representative community survey**

The final study was a nationally representative cross-sectional community telephone survey of 3002 Australian adults. Respondents were given one of six randomly-assigned vignettes that described a person in distress. The person in the vignette differed by gender (John/Jenny) and the overtness of his or her suicidality. The initial questions covered intentions and confidence in helping the person described in the vignette. Respondents who indicated that they had known someone at risk of suicide were asked a series of questions about their helping behaviours and those who had been at risk of suicide were asked about the help they had received. Other questions covered exposure to suicide and recall of media messages about helping a person at risk of suicide.

Our findings revealed that Australian adults generally have positive attitudes to suicide prevention and are confident in supporting someone they know well who is in severe distress or is at risk of suicide. In addition, they show appropriate helping intentions and helping behaviours toward such people. Most commonly, they listen and talk to the person at risk, offer them support, and encourage them to seek professional help. These responses are appropriate, being in line with both the recommendations made in our expert consensus study<sup>13</sup> (described above) and with Mental Health First Aid guidelines.<sup>20</sup> They were also noted as the most common 'helpful' actions provided to those respondents who themselves had been at risk of suicide.

However, about half of all respondents did not intend to ask questions to assess the immediate risk of suicide when someone was in severe distress, or to take steps to ensure the safety of that person. Men were less likely than women to ask direct questions about suicide risk and to take steps to ensure the safety of a person at risk. People aged 60 or older were also less likely than younger people to ask whether someone was thinking about killing themselves. A significant minority of respondents also endorsed their belief in the following statements: suicide happens without warning or any sign, asking someone about suicide might make them start thinking about it, and trying to help someone at risk of suicide could make the situation worse. Such attitudes are likely to

undermine community members' confidence in talking about suicide. Three non-recommended actions of reminding people who are considering suicide 'what they've got going for them', telling them how much their suicide would hurt their friends and family, and trying to convince them that suicide is wrong were also endorsed relatively frequently. Respondents who had been at risk of suicide identified helper responses that minimised their thoughts and feelings or indicated that the helper did not consider their mental health difficulties to be 'real' as the most unhelpful type of response.

A suicide prevention campaign aimed at family members and friends of people at risk of suicide could build on the existing positive attitudes and intentions and target those that are less desirable.

The sampling method used in this study has some major advantages. We used a random sampling method to gain a large sample of respondents for this study, and then weighted the resulting data to be representative of the Australian adult population. Unlike the sampling methods discussed so far, this method does allow generalisation of the findings to the Australian adult population, with some caveats. The main caveat is that since participation is voluntary and respondents were informed of the topic of the survey, they may be an over-representation of those with experience of severe distress, either their own or in supporting another. Experience with this topic might have made these community members more likely to participate. However, the sample size and weighted data allow us to use statistical analysis techniques to draw conclusions about the prevalence of intentions, attitudes and behaviours related to suicide prevention within the Australian adult population and to examine the relationships between variables of interest. This information, in conjunction with the other research findings, can therefore be used with confidence to inform development of a population-level suicide prevention campaign.

## Summary

These studies make a significant contribution to our existing knowledge about Australians' attitudes, confidence, intentions, behaviours and experiences related to suicide prevention. Our studies update previous research on helping people with mental health difficulties, but add unique perspectives by focusing purely on suicide prevention, and asking people who have been at risk of suicide to describe their experiences of receiving non-professional help. These studies combine the views of community members with little experience of suicide risk, those who have been exposed to the suicide of others, those who have experienced their own suicide risk or supported someone else at a time of risk, and suicide prevention professionals. Inclusion of a number of participant groups and methodologies has allowed us to triangulate our findings, providing greater confidence in our conclusions. The findings of the four empirical studies are largely consistent, and we summarise the key findings below.

Our research findings suggest that Australian adults generally have positive attitudes to suicide prevention and are confident to support someone they know well who is in severe distress or at risk of suicide. Most commonly, they offer assistance that those at risk find helpful by listening and talking to them, offering them support, and encouraging them to seek professional help. Most of our research participants who had experienced suicide risk were able to identify someone who had been helpful to them when they were at risk. These results are encouraging, suggesting a widespread willingness to help family members and friends in distress or at risk of suicide, and that

they are taking appropriate steps to do so. However, our research also showed actions that would assess level of suicide risk and help ensure the safety of the person at risk were far less common than general supportive behaviours. These actions include asking questions about suicidal thoughts, plans and means, and removing means. Only about half of participants in the national survey intended to take these actions, even when the person verbally expressed suicidal intentions. Since our, and previous, research has shown that only a minority of people express their suicide risk verbally and directly to others, it is important that community members are able to identify non-verbal signs of suicide and assess suicide risk. Participants in the qualitative research also expressed doubt in their own ability to determine when someone is at risk of suicide and stated a need for clear advice on how to identify someone at risk, approach them, ask direct questions about suicide, and the steps to take to assist them.

We also identified that a substantial minority of participants believed that suicide prevention requires the skill of a professional, that suicide happens without warning or without any sign, and that asking about suicide could make them start thinking about it or make the situation worse. Participants in the qualitative study also identified a fear of making things worse as a barrier to approaching someone who might be at risk of suicide. These attitudes have the potential to reduce confidence and intentions to take steps toward suicide prevention. The three non-recommended actions of reminding people who are considering suicide ‘what they’ve got going for them’, telling them how much their suicide would hurt their friends and family, and trying to convince them that suicide is wrong were intended, carried out, and experienced by a substantial number of respondents in both the national survey and the online questionnaire study. In relation to other unhelpful responses to suicide risk, participants from the two survey studies who had been at risk of suicide identified helper responses that minimised their thoughts and feelings or indicated that the helper did not consider their mental health difficulties to be ‘real’ as the most unhelpful type of response. Our expert consensus study also showed that experts believed promotion of the message ‘take all talk of suicide seriously and do not dismiss it as attention seeking or a ‘cry for help’ was imperative to a suicide prevention campaign.

## **Recommendations for a suicide prevention campaign**

Our research findings show a number of consistencies that highlight areas for improvement in Australian adults’ knowledge about attitudes, confidence, intentions and behaviours related to suicide prevention. Based on the key findings of this research, we have made a number of recommendations about possible inclusions in a suicide prevention campaign aimed at family members and friends of a person in severe distress or at risk of suicide. These are outlined below.

Such a campaign could include messages that communicate:

- that non-professionals can be of great assistance to people at risk of suicide though assisting the person to seek professional help is also encouraged;
- that non-professionals can seek information and training to improve their own ability to assist in an appropriate way;
- trying to assist, or asking or talking about suicide to, someone who is having thoughts of suicide will not increase the likelihood that they will attempt suicide;

- that all talk of suicide should be taken seriously not dismissed as attention seeking, a ‘cry for help’, or ‘not real’ because it relates to mental health difficulties;
- that those wanting to support someone at risk of suicide can seek professional support to do so and don’t need to ‘go it alone’;
- how family members and friends wanting to help a person at risk can access appropriate supports, particularly if a suicidal person is resistant to being helped or the helper feels that they are not equipped to help the person in distress, but wants to ensure the person at risk gains assistance;
- how to identify when someone is at risk of suicide, especially in relation to non-verbal indicators of risk such as behavioural changes like uncharacteristic reckless behaviour, increased drug or alcohol use, social withdrawal, agitation, insomnia, or dramatic changes in mood; and indirect verbal communications such as expressions of hopelessness, purposelessness or of being trapped with no way out;
- that family members should tell the person they care and want to help;
- that family members and friends can ask direct questions about thoughts, plans and means of suicide in order to assess the urgency of suicide risk;
- that family and friends should take direct actions to promote the immediate safety of someone at risk where imminent risk is identified, such as by calling a crisis line for advice and removing means where they have been accumulated;
- that family and friends can help the person to get assistance from a health or mental health professional or call a suicide help line as soon as possible;
- education about what not to do, including reminding people who are considering suicide ‘what they’ve got going for them’, telling them how much their suicide would hurt their friends and family, and trying to convince them that suicide is wrong.

In addition:

- targeting men, people aged over 60 years and people who speak a language other than English at home to increase their confidence in talking about suicide could be valuable;
- targeting men and people aged over 60 years to increase their intentions to carry out helpful rather than unhelpful actions and to encourage them to ask direct questions about suicide risk and take appropriate action to ensure the person’s safety could also be beneficial.

This report is accompanied by a communications framework, developed by *Whereto*. This communications framework aims to provide practical advice on how the findings of this research might be implemented into a suicide prevention campaign.

## Next steps

Our study findings and the communications framework can now be used to consider in more detail the development of a suicide prevention campaign aimed at family and friends of people at risk of suicide. This may be followed with the development and delivery of such a campaign. The results of national telephone survey enabled us to identify Australian adult community members' knowledge, attitudes, confidence, capabilities, intentions and behaviours in relation to identifying, approaching and supporting someone at risk of suicide, and knowing how to ensure their safety. These survey results provide a useful baseline on which to base an outcome evaluation of the effects of any resulting suicide prevention campaign. A full evaluation of any campaign would be best developed in conjunction with the campaign. Doing so allows ongoing evaluation of the implementation of the campaign components, as well as an evaluation of its effects. Implementation evaluation provides insight into why the campaign effects occur and is therefore help to identify areas for revision.

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