



Evidence Brief

Focus Area 3: Empowering earlier intervention.

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Definition and scope of this focus area

Empowering earlier intervention involves identifying individuals who are at heightened vulnerability for suicidal distress, providing brief support and facilitating access to specialist care, with the overarching aim of reducing the likelihood of escalation. This requires a coordinated approach from government and non-government services as well as broader community touchpoints associated with known periods of heightened vulnerability to suicide, such as situational stressors or navigating life transitions (1).

What are the key issues?

Australia's current approach to suicide prevention operates through a clinical health lens, with a focus on responding to an acute suicidal crisis. Structural change is required to shift the focus from reactive interventions to a prevention-focussed approach that responds to distress early (1). This requires a whole-of government approach that includes cross-sectional action and social participation (2).

Efforts must be made to proactively look for signs of distress, particularly for individuals who may be at heightened vulnerability to suicide, rather than relying on individuals to seek help. This involves capacity building across government services and community settings associated with known periods of vulnerability (e.g., education settings, financial institutes). Opportunities to utilise digital technologies, including social media platforms, to proactively look for signs of distress must also be explored. It is paramount that these interventions apply an equity lens with specified training for individuals who work with populations disproportionately impacted by suicide including Aboriginal and Torres Strait Islander people, the LGBTQIA+ community, individuals from culturally and linguistically diverse backgrounds and veterans (1).

Evidence suggests some of the greatest opportunities to empower earlier intervention are with adolescents and young people, and strategies that proactively target young people where they 'live, work and play' must be implemented to maximise this potential. Given adolescents spend much of their time at school, capacity building in the school environment is important. Educators should be empowered with the knowledge, skills and physical resources to identify and respond to an adolescent experiencing suicidal distress. **Expert Consultations** endorsed this approach.

Empowering earlier intervention also involves restricting access to the means of suicide and preventing the dissemination of harmful suicide-related information. The World Health Organisation suggest many suicides happen impulsively and means restriction can increase the opportunity for intervention (3). A comprehensive approach to means restriction must consider method preferences in different population groups and across geographic

locations; this requires the development and ongoing maintenance of appropriate data surveillance systems.

What is currently happening (in Australia)?

Key policy documents and frameworks identify the importance of empowering earlier intervention as part of a comprehensive approach to suicide prevention. Current government and non-government early intervention strategies can be broadly grouped into three key areas: training and capacity building, means restriction and reporting and communication guidelines.

Training and capacity building

Gatekeeper training offers a formal means to increase community capacity. Gatekeeper training is designed to provide community members with the knowledge and skills to identify and respond appropriately to people experiencing suicidal thoughts or behaviours (4, 5). Gatekeeper training is widely available across Australia with The Life in Mind website listing 59 courses under 'gatekeeper training'. Of note, as part of the New South Wales governments mental health recovery package, LivingWorks was funded to provide suicide prevention training for schools and the wider community that engage with young people. The Australian Defence Force Suicide Prevention program, a three-step program designed to build alertness and develop skills for action among defence members, and MATES in construction, industry-based suicide prevention training for construction works, are additional examples of Australia's capacity building initiatives.

Means restriction

Means restriction is an important population strategy for suicide prevention (6) and is a key component of Australia's systems-based approach outlined in the National Suicide Prevention Strategy (7). Gun control laws are often cited as an effective strategy to reduce access to the means of suicide. In Australia, access to firearms is restricted by the National Firearms Agreement. This agreement was enacted in 1996 and since this time there has been a reduction in suicide by firearms (8).

More recently, action has been taken to address the increasing rates of suicide due to poisons, including pharmaceuticals and other toxic substances (9). In Australia, it is currently possible to buy unlimited numbers of packs of paracetamol at supermarkets and pharmacies. The Therapeutic Goods Administration have recommended that the pack sizes available in both supermarkets and pharmacies be reduced (10). In response to this, the Australian government have recently announced (3rd May 2023) a reduction in the maximum size of paracetamol packets. From February 2025, paracetamol packs will be reduced from 20 tablets to 16 in supermarkets and from 100 tablets to 50 in pharmacies.

Means restriction is reliant on data that accurately captures trends in method preferences across geographic locations. The National Suicide and Self-Harm system (2019) was recently developed to integrate and disseminate data on suicide and self-harm (11) and can be used to inform future means restriction efforts. This is important given Australia's current approach to means restriction is insufficient. Despite the aforementioned strategies, Australia's overall approach is reliant on action at local level rather than a systematic approach at the national level. This is supported by the findings of the National Suicide Prevention Trial (12). This trial was designed to evaluate how a multi-component, systems-based approach to suicide prevention may be undertaken in the Australian context. Twelve trial sites across Australia undertook extensive planning and subsequently delivered a range

of evidence-based and innovative interventions. Only one of these sites undertook a means restriction activity (12).

Reporting and communication guidelines

Restricting access to harmful suicide-related information is an important component of early intervention. Reducing access to harmful suicide-related information, and promoting responsible and accurate communication, can empower earlier intervention by promoting help-seeking and reducing the dissemination of information that may increase suicidal distress. This can be achieved by developing communication and reporting guidelines to support safe dialogue around suicide. In Australia, Mindframe supports safe media reporting, portrayal and communication about suicide through the Mindframe guidelines (13) and Orygen provides guidelines (i.e., # chatsafe guidelines) for young people to safely communicate about suicide online (14).

What are the critical gaps (in Australia)?

Australia's approach to suicide prevention is disjointed and is largely implemented through a health lens with minimal input from other areas of government. More needs to be done to build capacity in key community touchpoints outside the health sector including education settings and financial institutions. In doing so, Australia must not implement a one size fits all approach but provide equitable access to early intervention (1). This may include specified capacity building activities for individuals who work with populations disproportionately impacted by suicide. Despite many national, state and territory frameworks including consideration of priority populations, the diverse needs of these groups have not been adequately addressed in practice (15, 16). Furthermore, Australia does not have a systematic process for identifying and enacting responses to emerging means of concern; this is a key gap that must be addressed.

Where should efforts be focused (in Australia)?

Australia requires a whole-of-government approach to effectively empower earlier intervention (17). There must be a commitment from all portfolios to prioritise early intervention and efforts must be made to leverage links across portfolios. Furthermore, opportunities within existing structures should be utilised. This includes improving data systems to allow timely data collection and sharing and ensuring the workforce responsible receive sufficient training and support.

Beyond this, efforts should be made to equip community members, particularly those who have regular contact with populations disproportionately impacted by suicide, with the knowledge and skills to identify and respond to an individual experiencing increased suicidal distress. This may be achieved by providing formal training (e.g., gatekeeper training) to staff working in school settings, financial institutes and social services organisations so they feel equipped to respond to a young person or client who is experiencing suicidal distress. This was supported by the findings of the **Expert Consultation** which suggest free mental health and suicide prevention training should be provided for the community, particularly for those in public facing roles. Furthermore, findings of the **Expert Consultations** emphasize the importance of ensuring mental health support and literacy is available in schools and universities.

Suicide prevention campaigns provide another alternative to improve help-seeking and build capacity to respond to distress. Evidence suggests media campaigns increase knowledge and awareness of suicide, but there is conflicting evidence on whether this translates into

behavioural change (18, 19). It is suggested that media campaigns are most effective if delivered as part of a multicomponent approach to suicide prevention. Findings from the **Expert Consultations** support the use of campaigns and suggest they should be implemented to increase understanding of mental health concerns, when to seek support for these, the supports available and how to access these. Such campaigns should also address the stigma associated with help-seeking. However, it must be noted that suicide messaging is complex and the positive impact of campaign messaging experienced by one group may have a negative impact on another group (20). As such, it is important that campaign developers get the messaging right (19).

Digital technology has the potential to empower earlier intervention, particularly for young people, and efforts should be made to harness this potential. Digital technology may be used for better screening and identification of individuals at risk of suicidality, to engage them early and/or provide avenues for care or specialised support (21, 22). Preliminary evidence suggests internet-based interventions delivered within the school environment may also form part of a comprehensive approach to early intervention (23). Early intervention strategies should also consider how to utilise social media platforms. A systematic review of 30 studies identified several key advantages to using social media for suicide prevention including the capacity to reach large numbers of people quickly through psychoeducation, to provide information to facilitate help-seeking and to foster a sense of connection. However, research in this area is in its infancy and further work is required to better understand issues of safety and efficacy.

FOCUS AREA 3 OBJECTIVES AND ACTIONS

Objective 1

Proactively look for signs of suicidal distress among individuals experiencing related situation stressors

Define objective

Empowering earlier intervention requires initiatives that proactively seek out individuals who may be experiencing an acute mental health crisis and/or increased suicidal distress; this may occur in the presence of other situational stressors (e.g., financial difficulties, housing stress) and/or during significant life transitions (e.g., transition from secondary school to tertiary education, transition from prison to community settings, transition from inpatient care to community care). Government and community touchpoints linked to such periods of heightened vulnerability should be utilised as opportunities to identify and engage in proactive early intervention.

Screening for suicidal distress and known risk factors for suicide may be implemented in health services as part of a proactive approach. Universal screening in paediatric health settings has been shown to identify at-risk young people (24) and evidence suggests this is feasible approach (25, 26). However, the COVID-19 pandemic has put a significant strain on the healthcare system, and this must be considered when developing universal screening for health settings. Of note, the effectiveness of universal screening is dependent the availability of support, resources and training. Screening interventions may also be adapted for delivery in online platforms; this is particularly important for identifying young people and individuals who may not be engaged with health or community services.

Describe range of issues or barriers potential action must address

Insufficient resources, at an individual-level and population-level, pose an important barrier. Staff working in key community touchpoints (e.g., financial institutions, social service organisations, education settings) may feel ill-equipped through lack of knowledge, skills and/or time, to proactively look for signs of suicidal distress and respond accordingly. This requires commitment from government to provide sufficient training options and from organisation leads to ensure their staff have access to appropriate training and the environmental resources to support learning. Furthermore, universal screening designed for the online environment must consider issues of safety and efficacy and how these differ from offline interventions.

Things we can build upon

Future action should leverage projects funded under the National Suicide Prevention Leadership and Support Program, particularly those funded under Activity 6: National Suicide Prevention Training, to build community capacity through training and whole-of-population campaigns. For example, under this scheme Reach Out Australia were funded to deliver evidence-based national digital media campaigns targeting young people aged 14 and 25 years and Headspace were funded to deliver a tailored mental health literacy framework to help university staff identify mental health issues.

Actions

- 1) Governments should work with financial institutions to increase the capacity and capabilities of their staff to identify and support borrowers who may be exhibiting early signs of suicidal distress.
- 2) Staff working within the social services sector must be equipped to identify individuals who may be experiencing suicidal distress, particularly those navigating significant life transitions.
- 3) Governments should incentivise universal screening and brief interventions for mental illness, suicide and harmful alcohol and drug use across health settings.
- 4) Governments should invest in digital technologies including mobile phone apps and web platforms designed to identify individuals experiencing distress.

Objective 2

Build capacity across government services and community settings to recognise and respond to people exhibiting signs of suicidal distress

Define objective

Government, government-funded and community services that are routinely in contact with individuals who may be at increased risk of suicidal distress due to life stressors and transitions are well placed to identify and engage these individuals. However, to capitalise on existing resources, staff should be equipped with the knowledge and skills to identify, engage and respond to people at heightened risk of suicide. This was supported by the findings from the **Expert Consultations**. This requires a concerted effort to identify, train and promote collaboration amongst individuals who are best positioned to intervene early while

ensuring they have access to the environmental resources, including access to appropriate referral pathways, to respond. Digital technologies should be used, where appropriate, to enhance training acceptability and reach.

Describe range of issues or barriers potential action must address

Governments must commit to prioritising evidence-based and compassionate-focused workforce development across sectors. To achieve this, training should be suitable for the target population and be implemented effectively within the constraints of individual workplaces and education settings. Evidence suggests knowledge and skill acquisition gained through suicide prevention training may diminish over time in the absence of refresher sessions (27) and therefore regular refresher sessions should be encouraged.

Things we can build upon

Gatekeeper training offers one opportunity to improve capacity and capability across the community. This involves training individuals who have regular contact with others within their community (i.e., gatekeepers) to recognise and support individuals who may be at-risk for suicide and self-harm (28). Evidence suggests gatekeeper training is a useful tool to improve knowledge and self-efficacy relating to suicide prevention (28); however, large-scale prospective studies are required to understand the mechanisms that can translate these into behavioural change to ensure improved public outcomes (4).

The Distress Brief Intervention (DBI) program is proposed as another means to build capacity across government services and community settings. DBI is a two-step program designed to provide support for people in psychological distress (29). Initially, trained frontline staff (e.g., police officers, paramedics, emergency department staff) provide a compassionate response to individuals experiencing distress. Trained community health or support workers then contact the individual (within 24 hours) to provide problem solving supports, wellness and distress management planning.

Actions

- 1) Governments should invest in internet-based interventions, particularly those delivered within the school environment, to build capacity and capability to respond to people experiencing distress within the school community.
- 2) Governments must invest in the roll out and evaluation of suicide prevention training. This must begin in key community touchpoints associated with periods of increased distress including education settings, financial institutes, and social services settings.
- 3) The trial and evaluation of the DBI program should be expedited with the aim of informing a scalable model to be made universally available.
- 4) The DBI trial should be extended by developing, implementing and evaluating a scalable early distress intervention targeting people experiencing (a) intimate relationship distress, (b) employment or workplace distress, (c) financial distress and (d) isolation or loneliness through relevant non-health settings, by:

- a. Developing a partnership between relevant health, social service, employment and family and community service portfolios to collaborate on the design, funding and implementation of the trial.
 - b. Requiring governance and ideally funding arrangements to be established in collaboration across organisations to strengthen integration with health and broader community and social service infrastructure e.g., local suicide prevention networks, regional suicide prevention coordinators in Primary Health Networks (PHNs) and Local Health Networks.
- 5) Extend the scope of the National Workplace Initiative to promote uptake of staff and manager training and workplace policies for responding to staff experiencing suicidal distress, with a particular focus on industries and workplaces with high rates of exposure to traumatic events (e.g. police).
- 6) Governments should allocate adequate funds annually to respond to the need for proactive suicide prevention outreach services as part of recovery responses to future disasters or economic crises.

Objective 3

Develop a national approach to means restriction that systematically identifies and addresses emerging means

Define objective

Reducing the availability and accessibility of the means to suicide is widely accepted as an effective approach to suicide prevention (3). Evidence suggests that most individuals, when restricted from their preferred means for suicide, do not seek alternative methods and when they do, the means chosen are less lethal (6). As such, Australia must develop a national approach to means restriction that systematically and effectively identifies and responds to emerging trends and acknowledges that certain methods may be linked to geographic locations.

Describe range of issues or barriers potential action must address

Data surveillance systems are required to identify preferred suicide methods and to determine how these differ between demographic groups and/or geographic location. These systems must capture as close to real time data to ensure means restriction approaches are reflective of community trends, noting suicide method preferences are everchanging (3). The development and ongoing maintenance of data surveillance systems requires ongoing funding (30) and therefore governments must provide financial commitment.

Things we can build upon

The development of a national approach to means restriction should draw upon the strengths of the National Suicide and Self-harm Monitoring system. This system was established in response to the objectives of the Fifth National Mental Health and Suicide Prevention Plan and is designed to integrate and disseminate data on suicide and self-harm (11). An independent evaluation, conducted by Melbourne University, found the system to perform well in terms of data quality and sensitivity, simplicity, accessibility, acceptability and usefulness (11). However, several areas for improvement were identified. To maximise the potential of the national suicide and self-harm monitoring system, the recommendations

outlined in the evaluation report (11), particularly those pertaining to the timeliness and coverage of data systems, should be addressed.

Actions

- 1) Develop a National Framework for a coordinated and systematic approach to identifying and addressing emerging trends, means and locations of concern in suicide and self-harm including:
 - a. Data surveillance mechanisms to ensure the systematic identification of emerging national and regional clusters of concern through available suicide and self-harm data.
 - b. Improvements to allow the geospatial mapping of available suicide death data to aid the identification of 'hotspot' locations.
 - c. An evidence-based plan for emerging trends in suicide and self-harm.
 - d. Processes for triggering national, state and territory responses through policy and funding mechanisms as required based on emerging data trends.

References

1. National Suicide Prevention Advisor. Connected and compassionate: Implementing a national whole of governments approach to suicide prevention (Final advice). Canberra, Australia; 2020.
2. Pirkis J, Robinson J. Understanding Suicide and Self-harm. 2022.
3. World Health Organization. Preventing suicide: A global imperative. World Health Organization; 2014.
4. Torok M, Calear AL, Smart A, Nicolopoulos A, Wong Q. Preventing adolescent suicide: A systematic review of the effectiveness and change mechanisms of suicide prevention gatekeeping training programs for teachers and parents. *Journal of Adolescence*. 2019;73:100-12.
5. Holmes G, Clacy A, Hermens DF, Lagopoulos J. The Long-Term Efficacy of Suicide Prevention Gatekeeper Training: A Systematic Review. *Arch Suicide Res*. 2021;25(2):177-207.
6. Yip PSF, Caine E, Yousuf S, Chang S-S, Wu KC-C, Chen Y-Y. Means restriction for suicide prevention. *The Lancet*. 2012;379(9834):2393-9.
7. Department of Health and Aged Care. National suicide prevention strategy for Australia's health system: 2020–2023. Australian Government; 2020.
8. Chapman S, Alpers P, Agho K, Jones M. Australia's 1996 gun law reforms: faster falls in firearm deaths, firearm suicides, and a decade without mass shootings. *Injury Prevention*. 2006;12(6):365.
9. Australian Institute of Health and Welfare. Suicide in Australia: Trends and analysis, 1964 - 2018. Canberra, Australia: Australian Institute of Health and Welfare; 2020. Contract No.: Cat. no. INJCAT 212.
10. Buckley N, Calear A, Christensen H. Independent expert report of the risks of intentional self-poisoning with paracetamol. Therapeutic Goods Administration; 2022.
11. Flego A, Dempster G, Cutler T, Robinson J, Pirkis J. Evaluation of the National Suicide and Self-harm Monitoring Project and System: Final Report Australian Institute of Health and Welfare; 2022.
12. Currier A, King K, Oostermeijer A, Hall T, Cox A, Page A, et al. National Suicide Prevention Trial: Final evaluation report. The University of Melbourne; 2020
13. Evermind. Reporting suicide and mental ill-health: A Mindframe resource for media professionals. Newcastle, Australia; 2020.
14. Thorn P, McKay S, Hemming L, Reavley N, La Sala L, Sabo A, et al. #chatsafe: A young person's guide to communicating safely online about self-harm and suicide. Edition two. Melbourne, Australia: Orygen; 2023.
15. National Mental Health Commission. The Fifth National Mental Health and Suicide Prevention Plan. Australian Government; 2017.
16. National Suicide Prevention Advisor. Compassion first. Canberra, Australia; 2020.
17. National Suicide Prevention Advisor. Shifting the focus: Supporting a comprehensive whole of governments approach to suicide prevention. Canberra, Australia; 2020.
18. Torok M, Calear A, Shand F, Christensen H. A Systematic Review of Mass Media Campaigns for Suicide Prevention: Understanding Their Efficacy and the Mechanisms Needed for Successful Behavioral and Literacy Change. *Suicide and Life-Threatening Behavior*. 2017;47(6):672-87.
19. Pirkis J, Rossetto A, Nicholas A, Ftanou M, Robinson J, Reavley N. Suicide Prevention Media Campaigns: A Systematic Literature Review. *Health Communication*. 2019;34(4):402-14.
20. Ftanou M, Skehan J, Krysinska K, Bryant M, Spittal MJ, Pirkis J. Crafting safe and effective suicide prevention media messages: outcomes from a workshop in Australia. *International Journal of Mental Health Systems*. 2018;12(1):23.

21. Torous J, Walker R. Leveraging Digital Health and Machine Learning Toward Reducing Suicide—From Panacea to Practical Tool. *JAMA Psychiatry*. 2019;76(10):999-1000.
22. Vahabzadeh A, Sahin N, Kalali A. Digital Suicide Prevention: Can Technology Become a Game-changer? *Innovations in Clinical Neuroscience*. 2016;13(5-6):16-20.
23. Robinson J, Hetrick S, Cox G, Bendall S, Yuen HP, Yung A, et al. Can an Internet-based intervention reduce suicidal ideation, depression and hopelessness among secondary school students: results from a pilot study. *Early Intervention in Psychiatry*. 2016;10(1):28-35.
24. Milliman CC, Dwyer PA, Vessey JA. Pediatric Suicide Screening: A Review of the Evidence. *Journal of Pediatric Nursing*. 2021;59:1-9.
25. Roaten K, Johnson C, Genzel R, Khan F, North CS. Development and Implementation of a Universal Suicide Risk Screening Program in a Safety-Net Hospital System. *Joint Commission Journal on Quality and Patient Safety*. 2018;44(1):4-11.
26. Horowitz LM, Snyder D, Ludi E, Rosenstein DL, Kohn-Godbout J, Lee L, et al. Ask Suicide-Screening Questions to Everyone in Medical Settings: The asQ'em Quality Improvement Project. *Psychosomatics*. 2013;54(3):239-47.
27. Holmes G, Clacy A, Hermens DF, Lagopoulos J. The Long-Term Efficacy of Suicide Prevention Gatekeeper Training: A Systematic Review. *Archives of Suicide Research*. 2021;25(2):177-207.
28. Yonemoto N, Kawashima Y, Endo K, Yamada M. Gatekeeper training for suicidal behaviors: A systematic review. *Journal of Affective Disorders*. 2019;246:506-14.
29. State of Victoria. Royal Commission into Victoria's Mental Health System: Personal stories and case studies. 2021.
30. World Health Organization. Live life: An implementation guide for suicide prevention in countries. Geneva, Switzerland: World Health Organization; 2021.