



Identifying priority areas of research to be addressed in the area of suicide prevention

Interim Report 2: Focus groups

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Chapter 1: Background

Consistent with the evidence-based approach of the National Suicide Prevention Strategy, the national Advisory Council for Suicide Prevention has recommended the development of a national suicide prevention research agenda and options to encourage further research in the field.

As a consequence, the Commonwealth Department of Health and Ageing has funded a consortium from the University of Melbourne (School of Population Health and ORYGEN Research Centre), Griffith University (Australian Institute for Suicide Research and Prevention) and Suicide Prevention Australia to conduct a project designed to identify future areas of research to be addressed in suicide prevention. The project aims to identify current priorities in suicide prevention, as evidenced by the kinds of research that have been funded and published in recent times. It also aims to identify future priorities, by considering the gaps in existing research, and by consulting with stakeholders in the field via focus groups and a web-based survey. A national research agenda will be recommended, based on the project's findings.

The current report outlines the findings from one component of the project, namely the focus groups with key stakeholders. Specifically, it considers future priorities for Australian suicide prevention research, as identified by participants in three focus groups.

Chapter 2: Method

Three focus groups were conducted. The first took place in at the University of Melbourne's School of Population Health in Melbourne on 31 July 2006, the second was conducted at the South East Health Service Offices in Sydney on 1 August 2006, and the third was run at the Australian Institute for Suicide Research and Prevention in Brisbane on 9 August 2006.

Participants for each focus group were purposively sampled in a manner that ensured representation from people who conduct suicide prevention research, people who use suicide prevention research, people who are involved in funding suicide prevention research, and people who have been affected by suicide. Seven participants attended the Melbourne focus group, 11 attended the Sydney focus group and 10 attended the Brisbane focus group.

Participants in each focus group were asked to consider the priority given to suicide prevention research to date, and then to discuss whether this emphasis should change in the future. The discussion was guided by a facilitator, using the following prompts:

- I'd like to start by asking you to think about our current level of knowledge about suicide prevention. What do we know?
- What don't we know?
- Thinking now about Australian suicide prevention research, what kind of research has taken priority in the last seven years (i.e., the duration of the National Suicide Prevention Strategy)?
- Can you comment on the overall quality of Australian suicide prevention research?
- Bearing in mind your responses to the earlier questions, what do you think should be the future priorities for suicide prevention research in Australia?
- What factors do you think should influence future priorities for suicide prevention research in Australia?

The Melbourne focus group was facilitated by Jane Pirkis, the Sydney focus group was co-facilitated by Michael Dudley and Sara Niner, and the Brisbane focus group was facilitated by Emily Schindeler. Sara Niner managed and recorded all three focus groups, took extensive notes at the time, and transcribed salient parts of the recordings later. Karolina Krysinska assisted Sara Niner at the Brisbane focus group.

Qualitative data generated from the focus groups were analysed for themes. Sara Niner conducted the analysis, consulting with Jane Pirkis on matters of interpretation.

Chapter 3: Results

Although perspectives, experiences and views of focus group participants varied, several recurring themes emerged. These are summarised below.

Evaluating the efficacy of interventions

The most commonly raised issue across all three focus groups was the need for greater emphasis on the evaluation of interventions. Various participants observed that good epidemiological data exist on rates of suicide among particular population groups, and a reasonable amount of research has been conducted on risk and (to a lesser extent) protective factors, but that research into the efficacy of given interventions has been relatively neglected to date. Many felt that research resources should now be targeted towards evaluating the gamut of potential suicide prevention interventions. As one participant put it, *'Efficacy is a major issue.'*

The majority of participants believed that suicide prevention interventions have been at best under-evaluated and at worst unevaluated. Some felt that no evaluation had occurred, others felt that not enough had occurred, and still others felt that that which had occurred had been ad hoc and/or inefficient. Several commented that interventions and programs were designed using flimsy evidence, based on anecdotes and personal opinions. One participant summed this up in the following way: *'The system does have some theories about how it could prevent suicide, such as how to manage discharged patients from emergency departments, but none of these care models are well researched or evaluated ... If we look at assertive follow-up, case care etc, it's done with good intention but no-one knows the effectiveness of it.'*

Several participants articulated the view that funding for intervention programs should explicitly include a budget for evaluation and knowledge development. One noted that this would require education on the evaluation process for service providers.

Some participants suggested specific intervention activities that required evaluation. These straddled the spectrum of interventions from mental health promotion (e.g., activities for strengthening resilience among young people), through primary and secondary prevention (e.g., early intervention and assertive follow-up with people presenting to mental health teams following suicide attempts), to treatment (e.g., cognitive behavioural therapy) and postvention (e.g., support groups for people who have attempted suicide and people who have been bereaved by suicide). In particular, there was consensus that interventions that seemed to show promise should be critically examined, such as *'the intervention programs that have resulted in a turnaround of young male suicides since 1997.'*

In a similar vein, several participants suggested that evaluation efforts should concentrate on people who have survived a suicide attempt. One participant, for example, said the following: *'Focus on those who have survived and what worked for them and what intervention helped at that time.'* Another made a similar but more specific comment, suggesting that *'We need details of the therapeutic alliance. What is the variable for the person to survive?'*

Some participants argued that evaluative evidence is particularly lacking for interventions with specific subgroups. Indigenous communities are a case in point. One participant noted, *'From the Aboriginal perspective, there must be more work done in remote Aboriginal communities where suicide has been a big concern and issue. They have no consultants or counsellors. How did the community cope with suicide and what successful mechanisms did they put in place to recover from it? Have they been able to stop others from doing the same? We need to find this out and develop a model to*

transfer this knowledge to other situations. We need real statistics and information on causes and effects on the groups of interventions. We often only have assumptions.'

Critically examining the response of the health and community service systems

Beyond specific interventions, there was a view that critical examination of the service delivery system was needed. Many participants were critical of the current health system, claiming that they were ill-equipped to assess and manage people who presented with suicidal thoughts or behaviours. One participant cited GPs as an example, noting deficiencies in their ability to deal with suicidality: *'My GP couldn't tell after 11 years [of suicide attempts] ... I got treatment for myself ... he didn't notice the scars on my hands.'* Another participant spoke of difficulties for clinicians in the public and private mental health sectors: *'The quality of risk assessment in the public sector is ordinary/limited. Many are afraid to ask a question that they fear the answer to. People in the private sector are terrified to ask because what do they do with the answer? No beds are available anyway, so what do you do? ... Maybe the question is what has to be put into place for them to feel safer to ask the questions.'* Several participants felt that the solution to these problems lay in research into structured clinical assessment processes, clinical guidelines, risk management tools and professional judgement processes.

Mention was frequently made of the fact that many people who die by suicide receive services from different health and community services in the months, weeks and even days before death, often in relation to prior suicidal thoughts or behaviours. Participants noted that co-ordination between different sectors is sub-optimal, and that better communication between services might prevent some people *'falling through the gaps.'* Several participants recommended that research to map these gaps could be useful in addressing them. Specifically, suggestions included research into the linkages between police and mental health services, between drug and alcohol services and mental health services, and between community services and clinical services.

Some participants stressed that a significant proportion of people who complete, attempt or consider suicide do not seek help, raising issues about the accessibility of services that warrant research attention. Some commented that it would be short-sighted to focus the entire research effort on those who do present to health and community services, making comments like: *'In all this we are still focusing on those people who present rather than on those people who don't present. The shocking question is: Why do people kill themselves? Is it factors outside the mental health system, way beyond clinical presentations to broader reasons? We need to have a systematic look at these issues.'* Several participants suggested that investigating the trajectory of suicidal behaviour via longitudinal methods may assist in this regard, because it might tease out where in the continuum people decide to act on suicidal ideation and why people choose to seek help or not to seek help. This in turn might provide clues about ways in which the health and community service systems can be optimally responsive.

A focus on high risk groups

Some participants felt that sufficient was known about high risk groups, at least in terms of their epidemiology. The majority, however, expressed the view that particular groups should still take precedence in terms of the suicide prevention research effort.

Men stood out as one such high risk group. Some participants felt that young male suicide has received significant attention, and that the reversal of their previously high suicide rate might mean that other groups should warrant research attention. Others argued, however, that young male suicide has not decreased among lower socio-

economic groups, and that these groups should maintain research priority. Still others mentioned different sub-groups of men, including older men, male prisoners and ex-prisoners, rural men, unemployed men, men in traditional male occupations and workplaces (e.g., builders, truck drivers), war veterans, recently separated men and men with relationship problems, and men with histories of sexual abuse. Several noted that many men do not seek help, and those who do are often not well served by services. One participant described this in the following way: *'Men don't access services because the services are disrespectful of men and the circumstances in which they might come to seek help.'*

Older people were another commonly mentioned group. Many participants felt that older people had been marginalised and had been paid insufficient attention in suicide prevention research. For this reason, a number of participants felt that older people should become the new priority in suicide prevention research. Specific suggestions for the research focus among this group included identifying reasons for their high suicide rates, evaluating interventions that work for older people, and examining the blurring between euthanasia and suicide among the elderly.

A number of other specific groups were mentioned by at least one participant as requiring research attention. These included people detained in or recently released from immigration centres, people in Indigenous communities, members of the stolen generation, people who have experienced domestic violence, children in the juvenile justice system, children of recently-separated parents, people with drug and alcohol problems, people exhibiting suicidal behaviours (e.g., those presenting to emergency departments having deliberately self-harmed), people who have been bereaved by suicide and/or have a family history of suicide, people with mental health problems (particularly those who have been recently discharged from mental health services) and crisis line callers.

There was an acknowledgement that individual participants would 'lobby' for a focus on the high risk groups with whom they were most familiar, which led to discussion of how to develop more objective criteria for selecting particular groups of interest. One participant questioned how decisions are and should be made, asking others to consider why some groups have received more research attention than others. He questioned whether high group-specific suicide rates have made the difference, or whether other factors, such as perceived attractiveness or vulnerability, might have had an influence.

Balancing individual risk factors with societal, environmental, cultural and political influences on suicide

Most participants acknowledged that there are some clear individual-level risk factors for suicide, such as mental illness. However, several participants argued that there are also broader societal, environmental, cultural and political influences on suicide that to date have been under-researched. Some attributed this to the largely bio-medical paradigm within which they perceived current suicide prevention research to be occurring.

Participants expressed this notion in different ways, using different examples. One mentioned suicide by those in or recently released from detention centres, suggesting that the political situation would need to be taken into account in researching appropriate and effective suicide prevention interventions for this group. Others talked about job insecurity, unemployment, rurality and low socio-economic status, recommending that anthropological and sociological issues must be addressed in understanding these factors and their impact on suicide. Still others mentioned cultural factors, suggesting, for example, that more research attention needs to be devoted to stigma and how this may impact on suicidality. One participant summed up the need to examine the influence that these factors can have on human lives in the following way: *'[We must] look at people's quality of life and the telltale signs [of despair].'*

Consideration of protective factors

Many participants felt that if individual-level variables were to continue to be considered, the traditional examination of risk factors should give way to a greater consideration of protective factors. Several participants heavily emphasised that a much deeper understanding is needed of people's capacity for resilience, hope and optimism. They felt that if these constructs were better understood, society would be better equipped to prevent suicide. Suggestions included looking at different levels of resilience in different communities, and examining why individuals in similar circumstances respond to traumatic and challenging events with different levels of optimism. One participant put this succinctly, claiming *'Research should be looking at what are the pathways to hope (and despair) in our society.'*

Methodological and related issues

A number of participants commented on the overall direction suicide prevention research to date, making suggestions about how different methodological approaches could improve the knowledge base.

Participants saw the value in real-world research, and advocated conducting rigorous evaluations alongside funded service delivery projects in a way that could provide evidence of effectiveness. One participant summed up the strength of this approach in the following way: *'Operational and applied research is more important than that done under artificial conditions.'*

A strong, recurring theme, however, was that deeper, more detailed and longer term research provided better quality and more useful information. Most felt that the research and evaluation efforts that sat alongside short term pilot project were insufficient to contribute to evidence about what works and what does not work, and concluded that there should be *'no more pilots!'* A number commented that it would be more useful to have fewer projects funded to a greater degree, with strong evaluation components built in. One participant who had just completed a rigorous evaluation as part of a tailored service delivery project noted that, *'if we had stopped at 12-18 months we would have had nothing, only ideas, not hard evidence.'*

Several participants commented on the need to involve people in meaningful ways in any research into suicide prevention. This point was summed up in the following way by one participant: *'Participate with people so they understand what we are doing and why we are doing it with them.'* There was seen to be an educative element to this approach, in that it could empower those involved in the research to become effective community agents in the area of suicide prevention. This was seen to be especially important for particular groups, such as people in remote Indigenous communities with few resources.

Multi-disciplinary research was also emphasised. This occurred in the context of several participants noting that suicide is not simply a medical problem, but also a social problem, and commenting that this therefore required the involvement of anthropologists and sociologists as part of research teams.

A few participants made mention of the fact that secondary analyses of existing data could complement the kind of primary research described above. Specific examples of routinely-collected datasets that could inform questions related to suicide prevention included coronial data and data from telephone help lines.

Several participants noted that irrespective of whether research used primary or secondary data sources, it needed to emphasise the Australian context. Several examples were cited where Australia-specific studies are required, including studies of

community structure and interventions to improve social cohesion, studies of male behaviour (including reticence with communication and help-seeking) in the Australian culture, and studies of differing protective factors in multi-cultural Australia. Some participants advocated a large-scale longitudinal study that followed a large cohort from infancy to adulthood, examining risk and protective factors for suicide.

Utilising research findings

Many participants indicated that research findings are not used optimally by relevant stakeholders. Some felt that researchers could do more to translate their findings into practice. One, for example, observed that research not only required recommendations but also action statements and commitments by researchers to follow them up. Others noted that researchers could do more to disseminate their findings in meaningful ways to communities, policy-makers, planners, clinicians and other practitioners, non-government representatives, other researchers, and those who use health and mental health services.

On a related note, a number of participants talked about the need to raise the profile of suicide as a public health issue and suggested that the media has a role to play here. In part, this role involves disseminating research findings (e.g., about risk and protective factors and about interventions that show promise). The role may be broader than this, however, and could involve reducing stigma, changing culture and encouraging help-seeking behaviour. Participants acknowledged the need to conduct media campaigns and related activities with caution, given the strong evidence that reporting of suicide can lead to copycat behaviours. They suggested that media activities themselves would need to be closely evaluated.

Developing a framework for suicide prevention that could guide suicide prevention research

Several participants drew together the above themes in a call for a cohesive framework for suicide prevention that could guide suicide prevention research. A number felt that the approach to date had been somewhat ad hoc, and that more strategic directions were necessary, contrasting the current approach to suicide prevention with that used to tackle the road toll. One participant summarised the idea in the following way: *'We need a framework against which we place criteria – macro-level for the whole population, such as education at a young age about resilience and protective factors, and then at the micro-level, training about intervention that can help us identify risk factors.'*

Chapter 4: Summary and conclusions

To summarise, focus group participants stressed that in future suicide prevention research efforts, priority should be given to evaluating the efficacy of specific interventions and examining the response of the health and community service systems. They felt that the epidemiological profile of suicidal individuals had been explored, at least with respect to rates and individual-level risk factors, and that the above evaluative activities should focus on groups identified as having particularly high levels of risk. Most saw limited value in continuing to explore individual-level risk factors ad infinitum, and felt that the time has come to move on to considering wider societal influences on suicide and individual-level protective factors. Many felt that evaluation efforts should employ mixed methods, should be cross-disciplinary and should be relevant to the Australian context. They also argued that there was scope for increasing the utility of research findings by communicating them in a manner that would enable them to be 'picked up' by policy-makers, planners and practitioners. Several called for a more cohesive framework for suicide prevention that could guide suicide prevention research.

A number of these findings resonate with those of another component of the current project, namely the review of published literature.¹ The review identified that, over the past seven years, the majority of published studies have been epidemiological studies of rates, and, to a lesser extent, individual-level risk factors. Scant attention has been paid to individual-level protective factors, or to societal influences on suicide, and relatively little has been devoted to rigorous evaluations of interventions, services, policies and programs. It is understandable, therefore, that the demand for evaluative research from focus group participants was so strong.

The fact that the majority of studies uncovered by the review were epidemiological in nature also meant that they tended to rely on quantitative data. This has contributed to quantifying the magnitude of suicide as a problem in the Australian community, and has highlighted particular groups who are at high risk. Arguably, however, it has occurred at the expense of qualitative studies designed to explore the experiences of those who have been affected by suicide and those who provide services for them. Focus group participants perceived this as an imbalance, and called for more qualitative studies of the trajectory of suicidal thoughts and behaviours, of why some people choose to seek help and others do not, and of what elements of particular interventions seem to be successful for particular individuals and groups.

The large number of epidemiological studies (and the corresponding dearth of social science studies) identified in the review also fits with focus group participants' perceptions that there is a need for more multi-disciplinary research. Several participants explicitly called for research input from anthropologists and sociologists, in order to better understand suicide as a societal issue.

To conclude, the findings from the focus groups provide some insights into where key stakeholders think future suicide prevention research priorities should lie. Interpreting these findings in a manner that informs a research agenda is not simple, and requires further contextual evidence on the status quo and additional data from a broader and more representative group of stakeholders. These will be provided by the two remaining components of the current project, the review of funded grants and the web-based survey, respectively. Preliminary analysis indicates that stakeholders are responding to perceived gaps in current research and are making informed suggestions about where future research efforts should be targeted, but it is premature to try to draw definitive conclusions. Once the findings from all four components are available, it will be possible to make clearer recommendations about how to re-direct Australia's suicide prevention research endeavours to help fill internationally-identified gaps in knowledge about what works and what does not work in suicide prevention.

References

1. Robinson J, Pirkis J, Krysinska K, Niner S, Harrigan S, Jorm A. Identifying Priority Areas of Research to be Addressed in the Area of Suicide Prevention. Melbourne: School of Population Health, University of Melbourne, 2006.

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