The impact of social determinants on suicide and how policy settings can help

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Suicidal behaviours are shaped by the social, economic and physical environments in which we live, otherwise known as the social determinants of health and wellbeing. Governments in Australia can change policy to reduce suicide rates. What policies have proven value? What do we need to know in order to prioritise and implement them?
Introduction

Suicidal behaviours are shaped by the social, economic and physical environments in which we live, otherwise known as the social determinants of health and wellbeing. Understanding how social determinants impact suicide is necessary to informing the development of, or improvements to, policy and practices that can redress social inequalities and prevent suicide at a population level.

Social determinants across the life course play a critical role in the development of mental illness^1^ and have a similar impact on rates of suicide. This is reflected in recent findings that suicide rates in Australia have increased in areas of low socioeconomic status and declined in areas of high socioeconomic status^2^. Here, we provide an overview of the social determinants and associated government policies that have a demonstrable impact on suicide rates. Rather than making specific policy recommendations, we aim to highlight the evidence for a range of policy areas, identify gaps in the evidence, and make recommendations regarding how the evidence can be considered in policymaking and contribute to ongoing policy via the Suicide Prevention Taskforce.

Background to suicide prevention in Australia

Recently, there has been significant investment from federal and state governments in evidence-based suicide prevention practices. Specifically, the investment has been in multi-level prevention approaches where regional suicide prevention alliances guide the simultaneous implementation of several evidence-based strategies (e.g. community training, school-based programs, improved media reporting of suicide, means restriction and improved crisis response).

The evidence for these multi-level, multi-sectoral models is derived from the European Alliance Against Depression (EAAD) model. The EAAD has the strongest evidence of effectiveness in reducing suicidal behaviour^3^ based on research in Europe, with some evidence to support a multi-level model in Japan (in rural but not urban settings)^4^.

The impact of Black Dog Institute’s LifeSpan integrated suicide prevention framework and other multi-level models of suicide prevention in Australia are not yet known; however, an international review of all evidence for suicide prevention concluded that ‘...no single strategy clearly stands above the others. Combinations of evidence-based strategies at the individual level and the population level should be assessed with robust research designs’^5^.

In Australia, this work has covered many regions and has resulted in a substantial shift in the way suicide prevention work is planned and carried out. Nevertheless, none of these models purport to prevent all suicides. While each of these models, if implemented well and with enough reach and dose, is likely to prevent a substantial proportion of suicides, more is required if we are to prevent the maximum number of suicides.

‘To create a genuinely effective, sustainable approach to suicide prevention, we need to have the hard conversations, to really look at how we live, how we communicate, and how we treat others, especially those who are vulnerable, and how our various systems—health, social, welfare, economic, education, and others—exacerbate or contribute to suicide.’

Black Dog Institute, Crisis and Aftercare Lived Experience Group 2020: Mok et al., Rapid Review for the National Suicide Prevention Task Force.
Building on Australia’s suicide prevention work

It is a sensible next step to build on the momentum created by the Australian place-based suicide prevention trials. While regional approaches to suicide prevention are an important part of suicide prevention efforts, they have not substantially addressed the role of social determinants in suicide.

These evidence-based practices must be supported by policy settings that focus on improving the social conditions in which people live so that regional, state and national strategies are working hand-in-hand. Understanding what, how, and which features of policy might reduce suicide risk is particularly important in Australia now: the National Suicide Prevention Taskforce (NSPT) is currently advising the government to consider a wide variety of policy responses to suicide and to build mental health and suicide prevention into their policy decisions. This has occurred to some extent already with the response to the COVID-19 pandemic in the form of higher welfare payments, employee payments, and tax relief measures. There are well established socio-environmental factors that shape suicide risk, such as poverty, unemployment, homelessness and domestic violence. The suicide rates among unemployed men are particularly evident. Geographical location is also linked with suicide rates. People living in rural and remote areas have a higher suicide risk compared to those residing in metropolitan areas. Men are at particular risk, which may be explained by cultural factors such as stoicism, social disadvantage, limited access to health services, access to means and capability, and limited access to job opportunities. Similarly, homelessness is associated with elevated suicide risk, with the majority of people who are homeless reporting suicidal ideation and attempts. Intimate partner violence is a strong risk factor for suicide attempts and ideation in women.

Evidence for the influence of policy on suicide

The social context of these risks means that governments have available to them a range of policy levers that can influence outcomes at a population level by addressing social inequalities.

There is evidence that health, economic and social policy areas can impact suicide outcomes.

A search of the scientific literature by the Black Dog Institute has identified several policy areas where there is at least one study demonstrating a link with suicide: unemployment and welfare support policies, improving access to treatment for mental illness, alcohol pricing and availability policy, reducing access to the means of suicide, justice and detention policies, LGBTQI+ marriage equality legislation, and austerity solutions to economic downturn (which put upwards pressure on suicide rates). Large studies of welfare support and suicide show that countries with more generous welfare payments and active labour market programs experience little or no increase in suicide during economic downturns, whereas countries with less generous welfare see substantial increases in suicide. Alcohol policy has a well-established impact on suicide, with lower availability, higher price, and older legal drinking age linked with lower rates of suicide.

Gaps in the evidence

What is not yet clear is which policies and policy settings are likely to be the most impactful and cost-effective in the context of reducing suicide risk.

This chapter identifies the broad range of policy areas or targets that might be considered. There needs to be consideration of mental health and suicide risk consequences of policy and budget decisions at state and federal government levels. Evidence for each policy area should be systematically reviewed and synthesised and gaps identified. Available evidence can be used to model the impact of different policy settings on suicide outcomes. While the focus of this chapter is on policies that have demonstrated impact on suicide outcomes, there are other social determinants of mental health and suicide which, while there is no policy research to draw upon, have a relationship with suicide. One clear example of this is geographical location. While this is a social determinant of suicide outcomes, we have not been able to identify studies of policies that might address this.
Current policy in Australia

As discussed earlier in the context of multi-level suicide trials, Australia has already adopted what might broadly be termed, universal prevention strategies, that directly or indirectly target suicide.

Strong media guidelines on reporting suicide is an example of a strategy that has directly targeted suicide prevention. There is a significant evidence base demonstrating that media reporting of suicides is linked to an increase in suicide37,38, which is frequently referred to as a Werther effect36. For instance, following the suicide of comedian and actor Robin Williams in 2014, there was a 10% increase in suicides in the US amongst men (22% increase compared to other non-fictional suicides) (see https://mindframe.org.au/).

Other strategies have been directed at reducing other harms but may have indirectly helped to prevent some suicides. This is the case with means restriction; e.g. stronger gun control legislation and the introduction of catalytic converters for pollution control39, and medication strategies aimed at reducing both intentional and unintentional self-poisoning. Maintenance of strong gun control legislation is sensible, particularly when given the relationship between population rates of gun ownership and gun-related suicides40.

While these strategies are welcome, a more targeted approach could be adopted by reviewing the existing evidence for the full range of policies with regards to their impact on suicide, investing in new research to evaluate the impact of specific policy changes, investing in impact and economic modelling to determine which policies and policy settings have the greatest potential to reduce suicide risk and under which conditions, and incorporating mental health and suicide risk impacts in policy decision-making processes. National system dynamics modelling in this area is progressing in Australia40 and internationally41. Recommendations have emerged from the modelling work at the Brain and Mind Centre, University of Sydney, to reduce suicide risk resulting from the pandemic: maintain JobKeeper payments to reduce financial uncertainty, provide further education support for young people, reduce social dislocation by minimising the spread of the virus, and increase real health service capacity, especially for those with more complex disorders41. This work could be expanded by building a stronger evidence base for policies as suggested above, and guided by the life course framework laid out by the World Health Organisation. This framework allows one to address policies that impact social determinants from the pre-natal phase through to older age (Figure 1), which demonstrates the cumulative effects of social determinants across the life span. What is needed is a process for considering health and suicide impacts of government policies. Research conducted on behalf of Suicide Prevention Australia found that 77% of Australians want all government decisions to consider the risk of suicide and have clear plans in place to mitigate any negative impacts following from those decisions42. This could involve changes to cabinet and budget expenditure processes to ensure review of potential impacts and development of mitigation strategies.

Conclusion

Place-based, multi-level models of suicide prevention are likely to reduce suicide rates if implemented at scale and depth; however, they must be supported by policies that address social determinants in order to improve suicide prevention.

Social determinants such as poverty, unemployment, homelessness, alcohol use and domestic violence are risk factors for suicide; their amelioration will lead to decreased suicide rates. A range of federal and state government policies can influence suicide rates, but what is not clear is which policy levers are likely to have the highest impact and to be most cost-effective.
Recommendations

There are substantial barriers to addressing the social determinants of health, including the reality that evidence is only one of many influences on policy decisions. There are gaps in our knowledge about how government policies can influence suicide risk. For evidence to be reflected within government policies, it must be linked to pragmatic solutions, strategies and outcomes that can be delivered within government frameworks. Government policies can influence suicide risk. For evidence to be reflected within government policies, it is only one of many influences on policy decisions. 

1. Incorporate the reduction of poverty, unemployment, homelessness, alcohol use, rural and remote isolation and domestic violence in all suicide prevention strategies and policies. Suicide prevention should also factor into policy and decisions in these other portfolio areas. Explicitly creating these links means creating appropriate whole-of-government structures, cross-portfolio funding and policy mechanisms and ensuring suicide risk and prevention is considered in non-health contexts.

2. Ensure the National Suicide Prevention Taskforce considers and advises on the full policy landscape, including non-health components, in its final recommendations to the Prime Minister. We support an ongoing commitment by governments to explore the social determinants of suicide risk from a whole-of-government perspective. Further, we encourage investment in research to identify gaps in the evidence and evaluate the impact of all social and economic policy settings on suicide.

3. Invest in data-driven, independently reviewed impact and economic modelling to determine the most impactful and cost-effective policies that can reduce suicide risk at the population level.

4. Consider mental health and suicide risk vis-a-vis all policy, regulatory and budget decision-making processes.

References

What can be done to decrease suicidal behaviour in Australia? A call to action

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