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POSITION STATEMENT

Responding to suicide in rural Australia

Suicide Prevention Australia

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About Suicide Prevention Australia

Suicide Prevention Australia (SPA) is a non-profit, community organisation working as a public health advocate in suicide and self-harm prevention, intervention and postvention. SPA is the only national umbrella body active in suicide prevention throughout Australia, promoting:

- Community awareness and advocacy;
- Collaboration and partnerships between communities, practitioners, research and industry;
- Information access and sharing; and
- Local, regional and national forums, conferences and events.

As a national organisation, SPA supports and assists both individuals and organisations throughout Australia, by promoting collaboration and partnerships in suicide prevention, intervention and postvention. SPA is supported by funding from the Australian Government under the *National Suicide Prevention Strategy*.

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To access accurate information about suicide and the portrayal of suicide in the media, please visit:
<http://www.mindframe-media.info/>

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Guiding Principles

- Research indicates that substantial differences in rates of suicide exist between Australia's rural and urban areas. However, little rigorous research has been conducted into the aetiology of rural suicide.
- The available data on rural and remote suicides in Australia reveals a multifarious problem. While this position statement does not intend to resolve all of these complexities, it does attempt to provide a firm basis of understanding from which further debate, discussion and strategic response may ensue.
- Discussions of geographically-related suicide rates and the development of correlative suicide prevention strategies should distinguish between the concepts of 'rural' and 'remote' as two independently heterogeneous concepts. Likewise, it should be remembered that 'remoteness' does not always necessarily relate to *geographic distance*, but can also refer to feelings of isolation.
- The role of improved mental health literacy, accessibility of services and resources, and coordinated initiatives that encourage help-seeking remain central to minimising the risk of suicide and self-harm in rural and remote areas.
- Social stigma remains a major inhibiting factor in the reluctance exhibited towards help-seeking among rural and remote communities, and may potentially preclude successful suicide prevention and crisis intervention strategies.

Background

Despite rising rates of suicide, it is only relatively recently that interest has been directed towards the relationship between suicide and geographical location. As a consequence, several studies have demonstrated that notable differences exist between urban-rural suicide rates (see, for example, Taylor, Page, Morrell, Harrison, & Carter, 2005; Page & Fragar, 2002). There have, however, been some exceptions to this among the available literature (see Cantor & Coory, 1993; Hassan, 1995).

More recently, research by Page and colleagues (2006) has contended that rates of suicide in some rural settings may have fallen. Despite this, rates of suicide have continued to rise in remote areas and among particular marginalised groups, including Indigenous people and disadvantaged males.

Statistical information pointing to the extent of suicide in rural and remote communities provides only part of the picture, given that the incidence of actual suicides in these areas is thought to be considerably higher than the number of *registered suicides*. The true intent of some deaths, particularly those by drowning, drug overdose and single vehicle, single driver car accidents, is difficult to determine. Additionally, the social stigma, guilt and shame attached to suicide and the resultant socio-economic and emotional implications on surviving family members, and the community more broadly, can also prompt a reluctance to provide a verdict of suicide in rural communities (Australian Bureau of Statistics, 2000).

Nonetheless, research has indicated that both young (15-24 years old) and older (55+) rural people are 30 to 50 per cent more likely to end their life by suicide than their urban counterparts (Baume & Clinton, 1997). In a study of farming suicides from 1988 to 1997, Page & Fragar (2002) found that farm manager suicides (approximately two-thirds of all farmer suicides) occurred predominantly in older age groups (55+ years).

Male youth suicide in rural areas has similarly been identified as a pronounced problem; estimated to be double that of metropolitan figures (Dudley, Kelk, Florio, Howard, & Waters, 1998; Sidoti, 1999). Rural inland towns with populations of less than 4,000 have experienced the most significant increases in male youth suicide (Dudley, Kelk, Florio, Howard, & Waters, 1998).

Indigenous people are also often at increased risk of suicide. Although the collection of reliable suicide statistics remains problematic, and suicides are often underreported, available evidence demonstrates that the rate of suicide among Indigenous people may be around "four times higher than the rates for non-Indigenous Australians" in major cities (Australian Institute of Health and Welfare, 2007, p. 211). In some remote Indigenous communities, this may be significantly higher.

For more on Indigenous suicide, download the position statement, 'Suicide Prevention and Capacity Building in Australian Indigenous Communities', available from the SPA website: <http://www.suicidepreventionaust.org>

While research has recurrently indicated that a variety of factors may coalesce to result in suicide, a frequently cited contributor to suicide aetiology in rural areas tends to be depression (Fraser, Judd, Jackson, Murray, Humphreys, & Hodgins, 2002). Increased attention has also, more recently, been directed towards an implied causal relationship between drought-related trauma and elevated rates of at-risk individuals (e.g. farmers and local businesspeople) in agricultural communities.

Longstanding challenges for rural communities (e.g. the ‘tyranny of distance’) have, more recently, been compounded by the effects of climate change (the full ramifications of which are yet to be determined). This has led to international trade pressures and socio-economic decline, which typically result in social and human costs (e.g. financial indebtedness and the guilt and shame often experienced as a consequence of financial insecurity or vulnerability, such as losing the family farm) that can be precipitators to increased suicide risk (see De Leo et al., 2005).

The causation of rural suicide is, however, far more complex than to be attributable to these factors alone. Rural suicidology, therefore, requires urgent exploration within the broader context of issues that are not limited by the traditional areas of research. Issues that appear to bear the most significant impact include, but are not limited to, the following underpinning social determinants:

- The devaluing of rural Australia as an important contributor to Australia’s social and economic fabric;
- The declining profitability of core industries in rural Australia, including an absence of understanding and support for these industries by metropolitan communities and governments;
- Consideration of the impact of ‘living at work’ – for instance, many individuals and families on rural and remote farming properties have little opportunity for reprieve and time away from difficult life experiences, such as drought;
- Development of improved understanding about the use of alcohol and other substances as a method of escaping difficult life experiences through ‘self-medication’;
- Consideration of the impact of depopulation on the social disintegration of rural communities and the possible impact of this on the mental health of rural and remote Australians;
- The availability and accessibility of mental health education and support in rural Australia;
- The impact of climate change on marginal and at-risk rural and remote communities and families (e.g. the state of the Murray Darling river system and the flow-on effects for towns dependent on this system);
- Masculinity in rural and remote areas – the stoic attitudes, attachment to the land, and ‘broad shouldered’ behaviours, particularly expressed by many rural men, which may mask their mental health issues;

For more on the risk factors associated with male suicide, download the position statement, ‘Men and Suicide: Future Directions’, available from the SPA website: <http://www.suicidepreventionaust.org>

- Same-sex attraction among rural youth;
- Social stigma and concerns regarding confidentiality; and
- An understanding of the correlation between social determinants, such as isolation and financial vulnerability, alcohol and substance abuse, and domestic violence.

SPA’s Position

While SPA supports the *Living is for Everyone (LIFE) Framework* developed under the *National Suicide Prevention Strategy*, it strongly encourages the immediate and active development of specific strategies that advance the issues unique to rural and remote communities not addressed by the LIFE framework and/or which fall outside the national strategy. SPA specifically seeks reform on a broader understanding of these issues, along with the following:

The heterogeneity of ‘rural’ and ‘remote’ communities

One challenge in addressing suicide and self-harm in rural communities is that the term ‘rural’ in its own right is, in many respects, arbitrary in that it is often variously described, depending on the classification system (e.g. RRMA – Rural, Remote and Metropolitan Areas) and/or measurements adopted (e.g. population density, size, distance etc). Indeed, no one universal definition exists and distinctions between states and territories can often be incomparable. This can, obviously, make comparisons of data from differently defined areas problematic.

Acknowledging these challenges, SPA believes it would likely remain counter-productive to the principles of intent and purpose underpinning this position statement to include a lengthy catalogue of the various definitions adopted. Therefore, for the purposes of the arguments outlined in this position statement, ‘rural’ is considered, very simply, to be that which is ‘not metro’.

SPA maintains, however, that it is important to identify the term ‘rural’ as being a heterogeneous concept. While some rural areas have been negatively affected over recent decades, others – for example, coastal and picturesque settings in close proximity to major urban centres – have prospered (Judd, Cooper, Fraser, & Davis, 2006). This difference between the coast and the inland may be reflected in differential suicide rates (Dudley et al., 1997).

Similarly, research demonstrates that, within the one community, some groups of people will likely experience “more of the negative aspects of rural life than the rest of the population” (Wainer & Chesters, 2000, p. 143).

With this in mind, SPA believes it is also important, when discussing geographically-related suicide rates and the development of correlative suicide prevention strategies, to distinguish between the concepts of ‘rural’ and ‘remote’. Despite being independently heterogeneous, ‘rural’ and ‘remote’ communities each have their own unique characteristics, challenges, and opportunities, influenced by history, population, and geography (among other factors). As such, SPA believes significant value can be found in approaching the two concepts of ‘rural’ and ‘remote’ separately.

Likewise, there is reason to suggest that it may be beneficial to furthermore distinguish between the unique challenges of farming and mining communities, as part of these broader rural and remote areas.

SPA believes it is important to remember that ‘remoteness’ does not always necessarily relate to geographic distance, but can also refer to feelings of isolation. Nonetheless, the challenges presented by geographic remoteness¹ – particularly experienced by many of Australia’s remote mining communities – should not be underestimated; especially in the implementation of effective ‘on-the-ground’ suicide prevention strategies and support mechanisms for rural and remote communities.

As Gregory & Murray (1997) point out, there are also likely to be general health differentials between metropolitan, rural, and remote communities. More specifically, life expectancy varies with geographic location.

The National Rural Health Alliance estimates that the difference in life expectancy between metropolitan and non-metropolitan areas is approximately four years, but could be as high as 13 years between more affluent metropolitan areas and low-ses (socio-economic status) rural areas (G. Gregory, personal correspondence, June 20, 2008).

Demographic statistics from the Australian Institute of Health and Welfare (2003, p. 7) specify that:

- Life expectancy for males tends to be 77.9, 76.7, 76.0, 75.3 and 72.2 years in major cities (MC), inner and outer regional (IR and OR), remote (R) and very remote (VR) areas respectively; and
- For females tends to be 83.9 (MC), 83.3 (IR), 82.6 (OR), 82.7 (R) and 78.5 years (VR) respectively.

Rural suicide risk factors

Despite similar rates of reported mental disorders, higher suicide rates in rural compared to metropolitan areas suggest that factors other than mental health may also be contributors and/or catalysts to rural suicide (Caldwell, Jorm, & Dear, 2004). Therefore, while mental health problems continue to contribute to rural suicide rates, it would be naïve to assume a straight line relationship exists between, for example, depression and suicide.

Likewise, SPA believes it is important to recognise that, while drought conditions have undeniably exacerbated problems that were already endemic in rural society, drought itself should not be considered the *sole contributing factor* to elevated rates of rural suicide.

According to Wainer & Chesters (2000, p. 143), rural people manage their health “in an environment of unbuffered exposure to adverse events such as drought, fire, floods, recession and economic rationalism”. The closure, restructuring and withdrawal of essential services such as banking, schools, hospitals, government offices, train services and publicly funded employment services (Wainer & Chesters, 2000) has significantly contributed to a declining quality of life in many rural communities.

These stresses are also often compounded by the effects of workforce migration, social fragmentation, and an ageing population (Hirsch, 2006). In particular, agricultural communities, which typically comprise many rural areas, often, in and of themselves, necessitate a challenging lifestyle characterised by long work hours, the responsibility of caring for crops and animals, and the financial, psychological, and emotional impacts of drought conditions, climate change and farming crises (Hirsch, 2006). Land degradation through drought carries with it “the hidden costs of damage to the social structure of farming communities” (King, 1994, p. 3).

Research shows that the gradual depopulation of a number of rural areas has also resulted in the loss of primary relationships and increased loneliness for many rural residents, particularly young men (Hirsch, 2006; Renwick, Olsen, & Tyrrell, 1982). The effects of these circumstances are known to greatly contribute to broader sociocultural, (mental) health, economic, and service-related problems and conditions, which in turn place individuals at greater risk of suicide and self-harm.

Suicide among younger people in rural areas

While available evidence demonstrates that there are a number of groups at-risk of suicide in rural and remote Australia, research demonstrates that, in relation to age-specific data, the burden of numbers and rates falls to younger people (Page et al., 2007). Granted, age-specific research on suicide in rural areas has traditionally focused on youth suicide rather than suicide by older rural Australians or older migrants in rural and remote areas (an imbalance that, notably, requires some remedy – see *Recommendations for immediate action*).

Baume & Clinton (1997) suggest that the factors contributing to suicide in young rural Australians can be attributed to two main categories: those related to structural factors, and those related to personal vulnerability.

¹ As typically defined and measured by the Accessibility/Remoteness Index of Australia (ARIA).

Structural factors implicated in the suicide of young rural people include unemployment; media representations of suicides; greater availability of lethal methods of self-harm in rural communities (e.g. firearms); barriers to access and use of mental health and health care services; and the consequences of a declining population, brought about by the increasing drift of many younger rural people to coastal and urban areas (Baume & Clinton, 1997; see also Dudley et al., 1992).

With regards to personal vulnerability, rural youth suicide is often associated with interpersonal factors, such as a previous or recent significant loss; and lessened resilience or a reduced capacity to cope with adverse life events. This is in addition to other social pressures, including the continuing crisis in agricultural regions and displacement from farms, which can often lead to the break up of the family unit (Baume & Clinton, 1997).

While being gay, lesbian, bisexual or transgender is not in and of itself a risk factor for suicide or self-harm, there is evidence to suggest that the pressures resulting from societal and family norms, and the subsequent discrimination, marginalisation and social exclusion experienced by these groups can also be a significant contributing factor to increased rates of suicide, self-harm and mental health problems – particularly among younger people (Costello et al., 2006).

SPA believes that the role of schools and other educational facilities/programs (e.g. MindMatters) as functional social organisations and support mechanisms by which to reduce the risk of social exclusion, and promote and protect the mental health and wellbeing (and improved schooling) of (distressed and at-risk) youth in rural areas should not be underestimated.

Access to means

SPA acknowledges that access to firearms and pesticides can contribute to suicide through increased lethality (Hirsch, 2006). Previous literature has indicated that, in Australia, 75 per cent of male suicides in rural cities, municipalities, and shires typically involve a firearm, and rates of suicide by firearm have tended to increase five-fold for rural dwellers with no corresponding increase for urban dwellers (Burnley, 1995; Dudley et al., 1992; Snowdon & Harris, 1992). From 1988 to 1997, firearms accounted for 51 per cent of all male farm suicides (Page & Fragar, 2002).

While firearms may have historically represented one of the most prevalent methods of suicide in rural and remote areas, there has been a significant reduction in suicide completions by firearms in recent years. Nonetheless, access to firearms remains an issue of considerable concern, given that the high lethality of such methods may convert many attempts into completed suicides as a consequence of the presence of a firearm (Baume & Clinton, 1997; Cantor & Slater, 1995).

The accessibility and availability of support mechanisms

Due to geographic constraints, rural areas often suffer from a shortage of health care facilities such as hospitals and clinics, and have difficulties in attracting and retaining new service providers and health care professionals (Hirsch, 2006). Lack of professional development opportunities and peer support also contribute to poor recruitment and retention rates of health professionals in rural and remote areas (Watson, Bannan, Clark, & Timmerman, 1999).

Where mental health and health care organisations do exist, SPA recognises that these are usually under-funded, comparable to urban areas; contributing to poor identification, treatment and support of at-risk rural and remotely located individuals (Hirsch, 2006).

Likewise, as both Penn and colleagues (2005) and Elliott-Schmidt & Strong (1997) point out, rural residents often tend to postpone seeking medical or associated services for illness, disability or psychological problems until it is economically or socially convenient. As Penn et al (2005, p. 276) observe: “Reluctance to expose their private lives to strangers or acquaintances from locally based services, or to undertake the journey to distant services where cultural or behavioural differences could be misunderstood, may impact on rural dwellers’ wellbeing.”

SPA acknowledges that improvements in the accessibility and availability of mental health and health care services, and encouragement of greater collaboration between general practitioners / primary care physicians and mental health professionals are fundamental to the early intervention and prevention of rural suicide (Hirsch, 2006).

SPA also recognises that the communal nature of rural communities, and non-traditional health service delivery mechanisms, including farm visits from financial counsellors and organisations such as Aussie Helpers and Black Dog Institute, and online technologies such as telepsychiatry and electronic social networking, should not be overlooked as protective factors to the risk of suicide and self-harm among rural individuals (Hirsch, 2006).

Social stigma and mental health literacy

Regardless of the causative factors, in rural areas, help-seeking for psychological difficulties, including suicidal and self-harming behaviours, is often neglected or resisted in response to a fear of community castigation. This is, more often than not, exacerbated for rural men and same-sex attracted male youth, in particular, by rural ideology, which typically promotes a strong work ethic and rugged individualism (Hirsch, 2006).

In a bid to address the elevated rates of male rural suicide, Kondinin Group and Wheatbelt Men's Health recently released, *Working with Warriors*, a free DVD on rural men's mental health. The first resource of its kind in Australia, the DVD unravels the pressures placed on farming men, the symptoms of depression and the key first steps towards managing the problem – for farmers, their families and the extended rural community.

More information on 'Working with Warriors', as well as a downloadable version of the DVD, can be found on the SPA website: <http://www.suicidepreventionaustr.org/Resources.aspx>

SPA recognises that 'community spirit' and the communal nature of many agricultural and rural areas may function as a potential protective factor to individuals at risk of self-harm or suicide. However, economic, geographic, and cultural barriers, including social stigma arising from the tendency for 'everyone to know everyone's business' in smaller rural communities, may also potentially preclude successful suicide prevention and crisis intervention strategies (Hirsch, 2006; Caldwell, Jorm, & Dear, 2004; Taylor et al., 2005). This is true, especially, of same-sex attracted rural youth for whom isolation, discrimination, and lack of access to information remain pressing problems (Quinn, 2003).

Strong connections to family, community, culture and religion can actually be a negative experience for some people and can result in negative health consequences (Costello et al., 2006). Therefore, it should be emphasised that it is the quality of relationships that matters, and that participation alone does not necessarily translate into acceptance, trust or reciprocity (Kushner & Sterk, 2005).

SPA believes social stigma is an issue that requires significant and urgent attention, given that it has, in a number of instances, impacted negatively on potentially valuable and beneficial capacity building initiatives in rural townships. For example, organisations such as Aussie Helpers and the Country Women's Association of Australia report that one of the greatest challenges in attracting people to mental health information sessions and community functions is the fear of social stigma; resulting in a reluctance to attend among those most at-risk.

Such sentiments are supported by the results of a recent study by Wrigley and colleagues (2005) of attitudes towards help-seeking for psychological problems among residents in a rural township in Northern Victoria. This study found that "higher perceived stigma was associated with more negative attitudes toward seeking help". Similar results were noted by Sawyer et al (2000). However, this was not associated with less willingness to discuss mental health issues with a general practitioner (Judd, Cooper, Fraser, & Davis, 2006).

The vicarious effects of drought-related trauma

While general practitioners may often be the first, and sometimes the only, provider of mental health treatment in rural areas (see Judd, Cooper, Fraser, & Davis, 2006), there is a dearth or absence of (mental) health professionals across all areas of the rural health workforce. According to the National Rural Health Alliance, this profile worsens with increasing remoteness; particularly with regard to the distribution of doctors, dentists, allied health professionals, and specialists (G. Gregory, personal correspondence, June 20, 2008). SPA believes this problem requires adequate funding of professionals, infrastructure, training and education, travel, and investment in Indigenous services, as well as the establishment of a minimum standard of access to rural health professionals.

Recent evidence demonstrates that other support workers, such as Rural Financial Counsellors (commissioned primarily to provide free and impartial financial assessment and advice to primary producers and small rural businesses), are also now playing a key role in the social, emotional, psychological, and stress-related support (and possible referral) of rural individuals.

SPA believes such situations have given rise to a new level of vicarious drought-related trauma, given that many Rural Financial Counsellors have been exposed to the practical dilemma of having to deal with the personal and psychological issues of their clients – something which is, more often than not, beyond the scope and capacity of their role (see Fuller & Broadbent, 2006) and adds a weight of responsibility and stress that many have not been equipped to deal with or resolve.

Similarly, SPA strongly believes that greater attention should be afforded to the vicarious trauma experienced by rural businesspeople, who often act as a 'sounding board' for farmers in crisis, and whose businesses typically carry (and sometimes fail under) the debt burden of local communities during times of rural economic downturn.

SPA also believes it is equally important to acknowledge the unique challenges faced by rural workers in mental health and associated areas of service provision. For instance, workers in smaller communities often encounter clients in both professional and social settings; blurring the distinction between work and private life and giving rise to concerns over the ability to apply ethical and professional skills in such a complex environment and to effectively meet the needs of clients and communities more generally (Penn et al., 2005).

Mental health and suicide prevention training

A publication released under the auspices of NSW Health titled, *The Evaluation of Mental Health First Aid in a Rural Area*, demonstrates that, when provided to members of the public by instructors from a local area health service, mental health 'first aid' (read: mental health response training) can function as an effective strategy in raising the mental health literacy of a rural community.

The report follows an initiative developed by the Centre for Mental Health Research and Australian National University in which a cluster randomised controlled trial and evaluation of mental health first aid was conducted in a rural area of New South Wales during 2003. The findings of the trial specifically indicated that mental health first aid, delivered in a rural community setting, has the potential to bring about positive changes in knowledge, attitudes and behaviour towards mental health problems and people with mental disorders (Jorm, Kitchener, MacTaggart Lamb, & Brand, 2007).

In south-west Queensland, a program provided by the University of Southern Queensland's Centre for Rural and Remote Area Health has similarly trained farm advisory and extension workers in the delivery of mental health first aid to farmers. It is anticipated that such programs will lower the stress levels of the agents who currently feel frustrated over their inability to help.

Other similar programs include (but are not limited to):

- Lifeline's *LivingWorks* community training program, which equips people to help others at-risk of suicide;
- The *Mental Health First Aid* program, auspiced by ORYGEN Research Centre, designed to train individuals to assist others who are developing a mental health problem or are in mental health crisis;
- The *Rural Frontline Training* program developed in consultation with rural communities by *beyondblue: the national depression initiative*, and targeted towards health workers and other key community and business leaders;
- FamilyCare's *Coach the Coach* preventative program, aimed at training local sports coaches to raise awareness of depression and promote good mental health and wellbeing among rural men;
- The *Working with Warriors* program, pioneered by Julian Krieg, Wheatbelt Men's Health Senior Educator and Western Australian representative on the board of Suicide Prevention Australia; and
- The *Rural Alive and Well Tasmania* program, designed to provide support to rural men and their families in 'exceptional circumstances' drought areas of the Southern Midlands and Central Highlands, where emotional and physical trauma brought on by the pressures of drought and economic hardship are prevalent.

SPA believes it is important that mental health 'first aid', complemented by suicide prevention training, reach as many members of remote, rural and regional communities as possible; bearing in mind that it is, quite often, family members, work colleagues, teachers, and/or sports coaches who are the first responders to an individual at-risk or in crisis.

Online technologies – bridging the 'tyranny of distance'?

Queensland's Allied Health Outreach Support Service has previously found that technological supports are recognised by rural counsellors as potentially effective and alternative solutions to issues of distance and isolation in rural communities (Hodgson, Spundle, & Belovic, 2000). Online support systems boast the potential to not only improve client care in rural communities, but also empower these same communities in the prevention of suicidal behaviours by enhancing capacity building and increasing community awareness and understandings of suicide (Penn et al., 2005).

Those individuals who 'slip through the cracks' may well be more effectively identified and supported when the community-as-a-whole is "aware of the risk factors and the support mechanisms that exist, and when available information is both appropriate and inclusive" (Burns & Patton, 2000; Penn et al., 2005). Similarly, online technologies enable individuals to access information and resources at their convenience with the added comfort of anonymity.

This is predicated, however, on there being a broader and more equitable provision of (broadband) internet services to rural and remote communities, as well as the capacity of individuals and families to afford internet access. Other limitations to the widespread implementation of online technologies and solutions, such as telepsychiatry, include ethical concerns over issues of confidentiality and client screening (Penn et al., 2005).

While it is recognised that video conferences and online technologies "cannot solve the inequity in service delivery", they can, as Penn and colleagues (2005, p. 278) suggest, function as a useful adjunct to – not a replacement for – current (face-to-face) service delivery strategies in rural and remote communities.

For example, ACROSSnet (Australians Creating Rural Online Support Systems), a collaborative Queensland-based participatory action research project and pilot website (www.acrossnet.net.au), aims to help rural mental health workers and members of remote and rural communities by providing convenient and interactive access to information fact sheets and resources, expert chat forums, and (peer) support and mentoring networks related to suicide and its prevention, intervention and postvention.

Recommendations for immediate action

- SPA strongly urges the Federal Government to consider implementation of many of the recommendations published in the final report of the 2020 Summit, as related to future directions for rural industries and rural communities, including:
 - Development of a rural social inclusion board;
 - Productivity Commission audit to examine parity of access between urban and remote, rural and regional Australia to quality health, education, housing, transport and social services as well as other community services and professional resources;
 - Increased professional development opportunities and peer support programs to assist in the attraction, recruitment and retention of health professionals and other skilled individuals, as well as families and businesses to remote, rural and regional areas of Australia;
 - Expansion of scholarship schemes to cover further education and other accredited training for remote, rural and regional students, trainees and apprentices;
 - On-ground extension of new research and innovation for and by rural professionals; and
 - A national strategy to ‘reverse the drift and revitalise the bush’.
- SPA endorses and encourages the swift and collaborative implementation of the Federal Government’s commitment to, from 2008-09, “boost the capacity of organisations in rural areas to provide allied and nursing mental health services”.
- SPA strongly recommends the further appointment of a dedicated mental health and suicide education coordinator within each local Area Health Service (or its equivalent) to assist in the promotion of mental health literacy, the connection of people to existing resources, and the delivery of coordinated suicide prevention and mental health first aid training and awareness initiatives among members of rural and remote communities (see, for example, the model adopted in Bundanoon, Southern Highlands, New South Wales).
- SPA argues that individuals, such as Rural Financial Counsellors, support workers, teachers, sports coaches, and small businesspeople in remote, rural and regional areas, should be provided with the requisite training to independently refer clients in crisis to the most appropriate and available mental health and health care services and resources (while also acknowledging their own stresses and emotive responses to such crises).
- On this point, SPA recommends the development of a mentoring system for general practitioners, nurses, allied health and other support workers to enable regular debriefing during the establishment and implementation of suicide prevention strategies in rural and remote areas.
- As a matter of urgent necessity, SPA strongly advocates the development of mental health education and awareness campaigns to reduce the prevalence of social stigma in rural and remote communities, and to improve support for those bereaved by suicide.
- SPA recommends greater development of online communication and information technologies to greatly reduce the barriers of distance that typically disadvantage communities in rural areas. This must be matched by a commitment from government to collaborate with telecommunications service providers to improve parity of access to cost competitive broadband internet networks and infrastructure across rural and remote areas of Australia.
- SPA strongly advocates that greater attention be afforded to detailed and rigorous research, as well as increased awareness, of specific issues such as, but not limited to:
 - Suicide and self-harm among older Australians and older migrants in rural and remote areas;
 - Possible connections between same-sex attraction and rural youth suicide;
 - The aetiology of Indigenous suicide in rural and remote settings;
 - Access to firearms as a contributing risk factor to elevated rates of rural suicide;
 - Single vehicle, single driver incidents in rural and remote areas;
 - The vicarious effects of drought-related trauma and climate change in rural and remote communities;
 - Service use with a specific focus on geographic areas;
 - The contextual and collective characteristics of rural communities that may hinder help-seeking, including the development of strategic responses to social stigma;
 - Suicide bereavement (incl. support activities for those bereaved) in rural and remote areas;
 - How understandings of suicide among rural communities can best be taken into account in the design, implementation and ongoing evaluation of suicide prevention and postvention strategies;
 - Media representations of suicide in rural and remote communities;
 - Debunking of myths about suicide still active in a number of rural and remote communities – e.g. ‘if they talk about it, they won’t do it’; and
 - Characteristics of suicide risk factors and preventive factors independently unique to ‘rural’ and ‘remote’ communities.

SPA commitments

- SPA will lobby the Australian Government and other relevant organisations / service providers for a commitment to improved funding to assist in the delivery of widespread rural extension and health care services; increased drought assistance; counselling services; suicide prevention initiatives; and capacity building in rural and remote communities.
- SPA will also lobby for the development of a national strategy aimed at improving the economic viability and long-term sustainability of rural communities, including training and apprenticeship schemes for younger people to counter the increasing trend of declining populations in rural and agricultural areas and, where viable, support (e.g. through billeting or boarding programs) for young rural people to travel to metropolitan areas for further education.
- SPA will continue to advocate for improved awareness and understanding, by those living in urban and metropolitan areas, of the challenges faced by remote, rural, and regional Australia.
- SPA will continue to advocate for greater understanding and support of those bereaved by suicide in rural and remote communities, including the development of activities and initiatives that reach and benefit them.
- In partnership with other relevant organisations, SPA will continue to endorse the implementation of early intervention and educational programs (e.g. MindMatters), role model strategies, and responsible media reporting that reaches out to rural youth; promoting awareness, understanding, skills and the capacity for resilience in responding to life challenges.
- SPA will continue to argue that greater collaboration should be actively sought between general practitioners / primary care physicians, mental health professionals, and other available health care services and resources to enable early intervention and prevention of suicide in rural and remote areas of Australia.
- In partnership with other relevant organisations, SPA will seek to ensure that greater attention is paid to the vicarious effects of drought-related trauma and climate change.
- SPA affirms that the diversity of message must not be ignored. Any comprehensive strategy aimed at securing the sustained social, economic, and psychological wellbeing of individuals and communities in rural and remote Australia must be designed to meet the needs of (among others) disadvantaged men; same-sex attracted rural youth; women on the land; older as well as younger rural Australians; farmers; Indigenous people; forced refugees and migrants; war veterans; members of mining communities; financial counsellors and other support workers; small businesspeople; those who have experienced suicidal ideation; and those who might otherwise 'slip through the net'.
- SPA will seek to ensure the valued contributions of rural people with lived experience of suicidality and those bereaved by suicide be embraced via, for example, compassionate engagement and involvement in ethically sound and methodologically robust research.
- SPA recognises the value of celebrating the history and successes of rural communities, and actively supports the development of greater tourism opportunities in these areas as a means of realising this and as a mechanism by which to help improve the sustainability and wellbeing of individuals and communities in remote, rural and regional Australia.

More information is available via the SPA website: <http://www.suicidepreventionaust.org>

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