



Centre for
Rural & Remote
Mental Health

Suicide & Suicide Prevention in Rural Areas of Australia

Briefing Paper

Rural Suicide Prevention Forum

11th April 2017

Acknowledgments

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This paper has been prepared by: Trevor Hazell, Susan Beaton, Professor David Perkins, Tessa Caton, Dr Hazel Dalton and Vanessa Delaney.

The CRRMH would like to acknowledge the following organisations for their work in assisting us to deliver this forum on such an important topic:



Royal Agricultural Society of NSW

About the Centre for Rural and Remote

The Centre for Rural and Remote Mental Health (CRRMH) is based in Orange NSW and is a major rural initiative of the University of Newcastle and the NSW Ministry of Health. Our staff are located across rural and remote NSW.

The Centre is committed to improving mental health and wellbeing in rural and remote communities. We focus on the following key areas:

- the promotion of good mental health and the prevention of mental illness;
- developing the mental health system to better meet the needs of people living in rural and remote regions; and
- understanding and responding to rural suicide.

As the Australian Collaborating Centre for the International Foundation for Integrated Care, we promote patient-centred rather than provider-focused care that integrates mental and physical health concerns.

As part of the University of Newcastle, all of our activities are underpinned by research evidence and evaluated to ensure appropriateness and effectiveness.

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In every state in Australia, the rate of suicide among those who live outside the greater capital cities is higher than that for residents that live within them, and the rate has risen much higher in rural areas over the period 2011-2015.

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Introduction

When a person dies by suicide, or engages in self-harm, or makes a suicide attempt, the impact on their family and friends and the people who know them is tremendous. It is a traumatic event leading to sometimes intense feelings of sadness, bewilderment, anger and regret. Often this trauma is experienced in isolation and without support.

Sadly, people in rural areas are more likely to take their own lives than those in metropolitan areas. Rural communities often have poor access to health and social services and are more likely to experience events or situations that place them at greater risk.

This Briefing Paper has been assembled to support a discussion about how to address rural suicide prevention at the upcoming forum at the Royal Sydney Easter Show. We hope that interested parties will consider the issues and examine how they can contribute to reducing the number of our neighbours in rural and remote Australia who die by or attempt suicide.

The Briefing Paper draws attention to several topics and raises questions which stakeholders can think about before the event. Figure 1 outlines the structure of this Briefing Paper.

Figure 1: Briefing Paper overview



1. Defining Rural

What is rural?

It is difficult to find a simple way to define or describe “rurality”. For statistical purposes, the terms “Metropolitan” “Inner Regional” “Outer Regional” “Remote” and “Very Remote” are used. While helpful, the terms do not reflect the diversity of what ordinary people think of as “rural”. For this paper the term “rural” is broadly inclusive of a diversity in geographic characteristics and types of human occupation and activity, such as:

Regional Centres

Areas which have a diverse population, a multi-functional economic and social base, which provide specialist educational, health and other professional services to a widely dispersed geographic area which encompass rural industries such as agriculture or mining etc. (e.g. Wagga Wagga)

Rural Towns

Places of varying size which mainly provide services that support local industries such as agriculture, mining, recreation and tourism (e.g. Narrabri)

Remote Small Towns

Places which often exist along minor highways or at the crossroads of roads and railway lines, with only a small range of services catering mainly for the needs of travellers and those in the transport industry.(e.g. Ivanhoe).

Open Countryside

Areas that are non-urbanised, and less densely populated. The land might be used for industries such as farming, forestry, mining, tourism and recreation. Some areas may be unoccupied and not utilised for any human activity at all.

Even large metropolitan areas such as Newcastle and Wollongong are strongly linked to traditional rural industries (farming and mining) as distribution points of rural produce to national and overseas markets. Primary production is included in the industrial mix of these cities. Both are still geographically separated from Sydney by areas of land which are either dedicated to primary production rather than urban living, or are protected Crown Land or National Parks.

Rural localities can also be differentiated by the number and diversity of occupational groups and the availability of professional services. Typically, small rural towns and remote localities will be characterised by having less occupational diversity and fewer, if any, professional services, and no specialist health services. Place-based suicide prevention needs to begin with an assessment of the characteristics, needs and capacity of the local community.

Things to think about



Because there is no one way to describe the social, economic, geographic, climatic, or environmental characteristics of rural areas, the prevention of rural suicide requires us, as Lobley and colleagues (1) state, “**to drill down to differences between rural locations rather than to simply contrasting rural and urban contexts**”.

2. Rural Advantages

The positives of a rural lifestyle

“People in rural areas regularly score better than their major city counterparts on indicators of happiness. This may be testament to the positive aspects of rural life, and the interconnectedness of people living there. In rural areas, there are higher levels of civic participation, social cohesion, social capital, volunteering and informal support networks from neighbours, friends and the community”. (2)

Characteristics such as these are an important platform upon which to build a strategy to reduce rural suicide.

Resilient communities demonstrate the strength of their underlying social capital when they need to cope with downturns in economic capital and the effects of natural disasters and other impacts on their environmental capital. In less populated rural areas, with greater social isolation, the social capital may not be sufficient to adequately cope with adversity.

The resilience of the local community is critical to the resilience of individuals and families that belong to that community. While in the short-term communities may need help from outside to cope with certain negative circumstances, their longer-term resilience will be enhanced by the extent to which those outside resources complement and enhance local capability.

While generalisations such as these are borne out by population-level research, they disguise the fact that these benefits may not be experienced in equal measure by everyone and everywhere in rural areas. Consequently, efforts need to be made to challenge and support rural communities to extend social connectedness, and to reduce the exclusion of some individuals based on their race, culture, sex, sexual preference, income and location.

Rural settings also hold the potential for powerful collective planning and problem-solving efforts and this may be harnessed to address the problem of rural suicide.

“Rural and small-town settings offer unique opportunities for inter-professional collaboration and the engagement of different elements of local society, including indigenous communities, economic interests and broader elements of civil society. While networking and partnering are possible in any health service environment, we contend that rural environments offer a much less cluttered setting in which to observe the processes and outcomes of primary health care development.”

This overview of rural health and place, therefore stresses the need to recognise the diverse conditions of rural living, the distinctiveness of rural health service environments, and the possibilities and potentials for rural healthy community development.” (3)



Things to think about

How can efforts to reduce rural suicide be developed so as to **take account of each community's strengths and opportunities**, to build local initiatives and leadership, and to strengthen the overall resilience of local rural communities?

3. Rural Risks

Risk factors for rural communities

People living in rural areas experience unique conditions that can increase the risk of ongoing mental health problems and suicide, especially if emerging problems are not recognised and addressed.

For many living in rural and remote areas, their future economic security is somewhat out of their control not totally and hence they experience higher levels of insecurity than those who live in cities, who might have greater opportunities to gain employment and provide for themselves and their families.

For those who own, manage and work on farms, their current and future security depends very much on the vagaries of the seasons. Even when seasonal conditions suggest a hopeful future, their lived experience reminds them of the realistic risk of future adverse conditions, such as too much or insufficient rainfall, too high or too low temperature, hail, frost, fire etc. In addition, the income from even successful farming yields is dependent on the external market at the time of selling the produce.

This uncertainty extends to those whose livelihoods depend on the prosperity of farming, with many small businesses relying on being paid sometime in the future, if, and when there is a successful season. One small business woman, whose small town is losing its retail businesses, said recently that she feels powerless because:

*“I can’t spend money in the town until I get paid,
and I’ll get paid (hopefully) when the farmer does”.*

While there is considerable literature on the threats to the mental health of workers who drive, or fly into work on mines, it must be remembered that there are also many occupations associated with agriculture (such as truck drivers and shearers) that involve workers being away from their home for substantial periods of time, with increasing risks to health and mental health.

A further stressor in many rural communities is the actual or planned change in the economic basis of their community. On the Liverpool plains for example, there is great concern being experienced by many who do not want any expansion of the coal seam gas industry, while at the same time others who are greatly concerned about the decline in small towns and see the new jobs as necessary for the future of the region.



3. Rural Risks

Rural decline is a further consideration, especially for those who do not have the option of moving to another more prosperous location. They may witness the gradual closure of small businesses in nearby small towns. They can see they are going to face increasing costs in order to access essential services. Rural decline weakens both the economic and social capital of the area.

A further consideration is the reluctance of many in rural areas to utilise support services when their circumstances lead to feelings of anxiety or depression. Apart from the reluctance to admit that they may have a problem there is also the perception that services may not be helpful.

“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.” (4)

Despite this, it is true that most rural people thrive despite the underlying uncertainty of rural living. Their individual strengths, their previous experiences, and the beneficial characteristics of living in supportive rural communities are just some of the factors that contribute to their resilience.



Things to think about

There are unique stressors for many people living in rural areas which may contribute to higher rates of suicide. Recognising and addressing these stressors will be an important consideration for the prevention of suicide in the years to come.

A plan to reduce rural suicide in future years will **depend on rural people being resilient and being supported by a resilient rural community.**

How can we best **mobilise local communities to take ownership** for building the resilience of those who make up the community, as well as of the community itself?



4. Rural Health

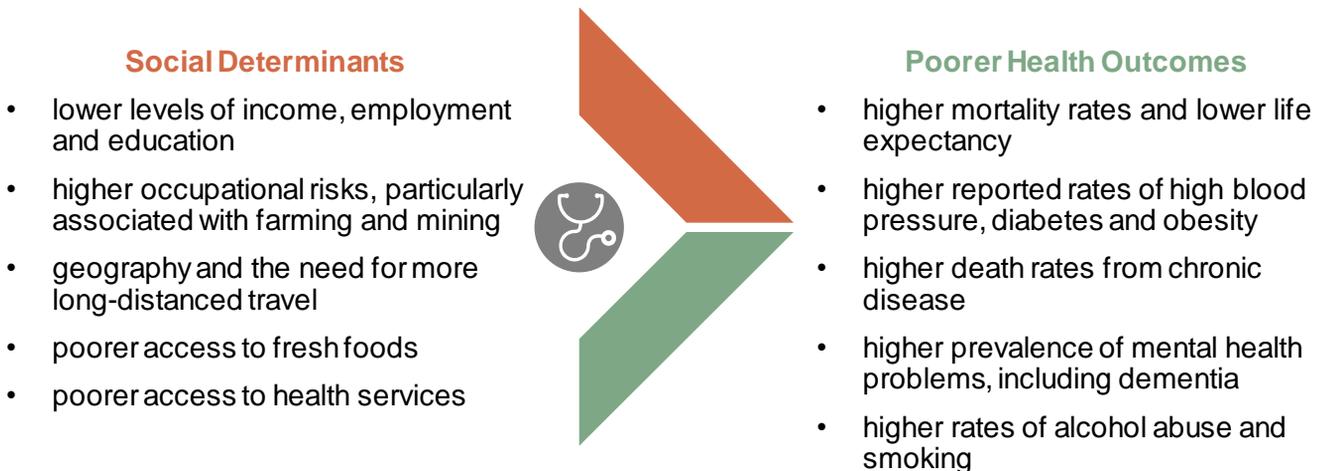
The health status of rural Australians

The following excerpt from a publication by the Garvan Institute (5) provides a succinct summary of rural health status:

“The health of Australians in rural and remote areas is generally poorer than that of people who live in major cities and towns.”

Commonly cited reasons for this poorer health status include substantial differences between the metropolitan and rural and remote populations in relation to the social determinants of health. Figure 2 illustrates the relationship between these social determinants and the poorer health status of rural Australians.

Figure 2: Social determinants of health and the health status of rural Australians



Some of the social determinants of health listed above may not appear to be ‘distinctly rural’. However, in rural and remote communities, the health effects of these factors are further compounded by poor access to communications (such as broadband, mobile coverage and public transport) and environmental challenges (such as droughts, floods, and bushfires).

Note: The infographic and quote above utilises information from the Garvan Institute Report on Research and Rural Health (5).

Things to think about



If we are to reduce rural suicides **in the long term**, we need to work out how to address the social determinants of health, using strategies based on knowledge about these determinants as they apply to individual rural locations.

Do we have **sufficient information about the social determinants of health** to underpin the planning of rural suicide prevention, given the diversity of different rural communities?

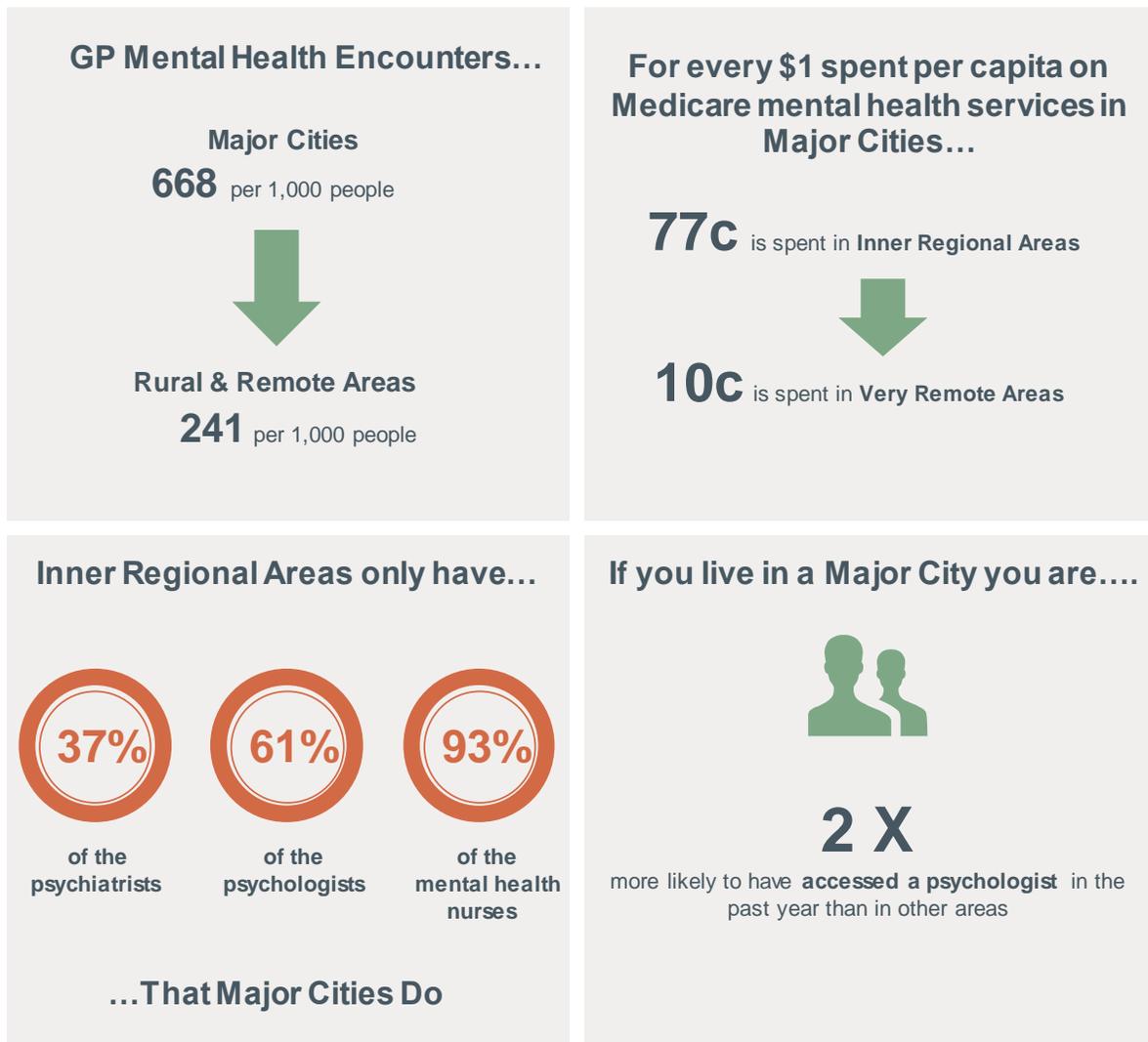
5. Rural Mental Health and Wellbeing

Access to mental health services

Overall, rural Australians report higher levels of life satisfaction than those who live in major cities. Nevertheless, national surveys indicate that the prevalence of the common mental illness is similar across the country (around 20%).

The impact of mental illness on the lives of those living in rural areas, however, is greater due to differences in access to and uptake of effective treatments and services. Figure 3 outlines the differences between major cities and other areas in access, utilisation and mental health spending.

Figure 3: Access & utilisation of mental health services



Timely diagnosis, treatment and ongoing management of a mental health condition in rural and remote areas is likely to occur later or not at all, often resulting in an increased likelihood of hospitalisation and sometimes leading to the most tragic of outcomes - self-harm and suicide.”

Note: The infographic and quote above utilises information from the 2017 Fact Sheet published by the National Rural Health Alliance (6).

5. Rural Mental Health and Wellbeing

The impact on rural carers

The impact of mental illness on those who live with, know or care about a person who experiences a mental illness in a rural setting can be considerable. They experience frustration about lack of services or access to services, the burden of assisting the ill person to access treatment, and the effort and cost of visiting them while they are in a distant hospital can occur. Concern about the ill person's social isolation and relatively easy access to the common means of suicide when at home must also be a great stressor for rural carers. The stress, frustration and broader concern for the viability of rural communities due to poor access to health services is exemplified by the ABC's recent article on the Grenfell community. (7)



Things to think about

If we are to reduce rural suicides **right now** we need to start reducing the gap in access to and use of evidence-based medical and psychological treatments for those who are experiencing mental distress.

Who should be involved in leading, planning and implementing a strategy to address this challenge?

In addition to increasing access to and quality of professional medical and psychological support for those who are suicidal, **what other steps might need to be put in place** to reduce future risk, such as increasing social connectedness, and addressing economic hardship?

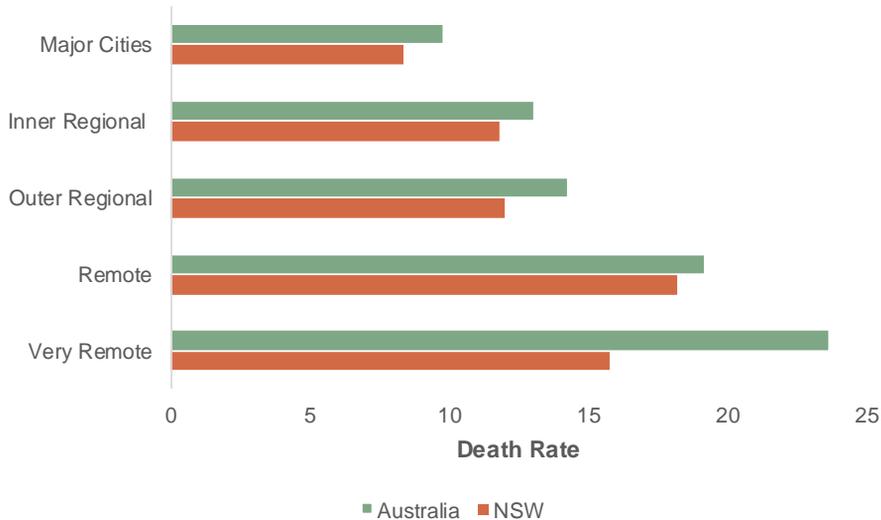


6. Rural Suicide

Rural suicide statistics

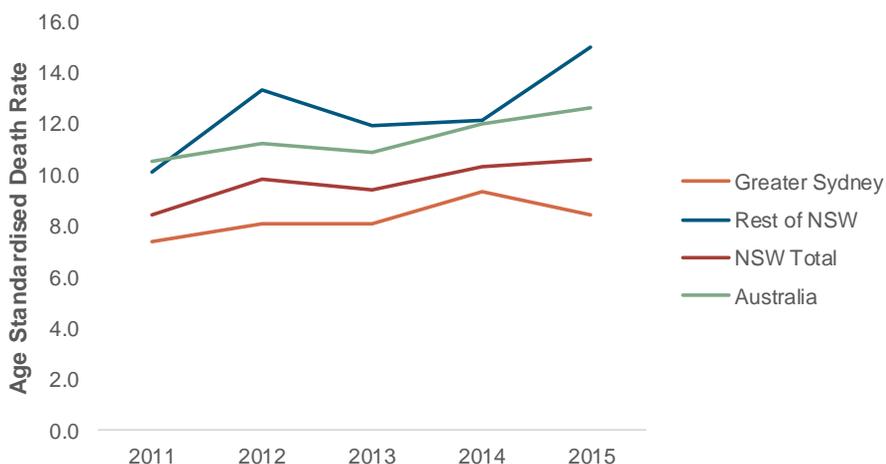
Put simply, if you live outside one of the major cities, the rate of suicide will be higher in comparison, as is shown in the Graph 1.

Graph 1: Death rate from suicide and self-inflicted injuries, 2010-2014 (8)



Perhaps a less well-known fact is that the rate of suicide has risen more sharply outside of the major capital cities during the period 2011 to 2015 compared to the rates for the greater capital cities; this trend is illustrated in Graph 2. Note the widening of the gap between the two.

Graph 2: Suicide, age standardised death rates, 2011- 2015 (9)



Things to think about

The phenomenon of rising suicide rates is particularly marked in localities outside of greater capital cities.

How can we focus more on turning around the current pattern of rising rates in rural and remote communities?



7. Suicide by Aboriginal and Torres Strait Islander People

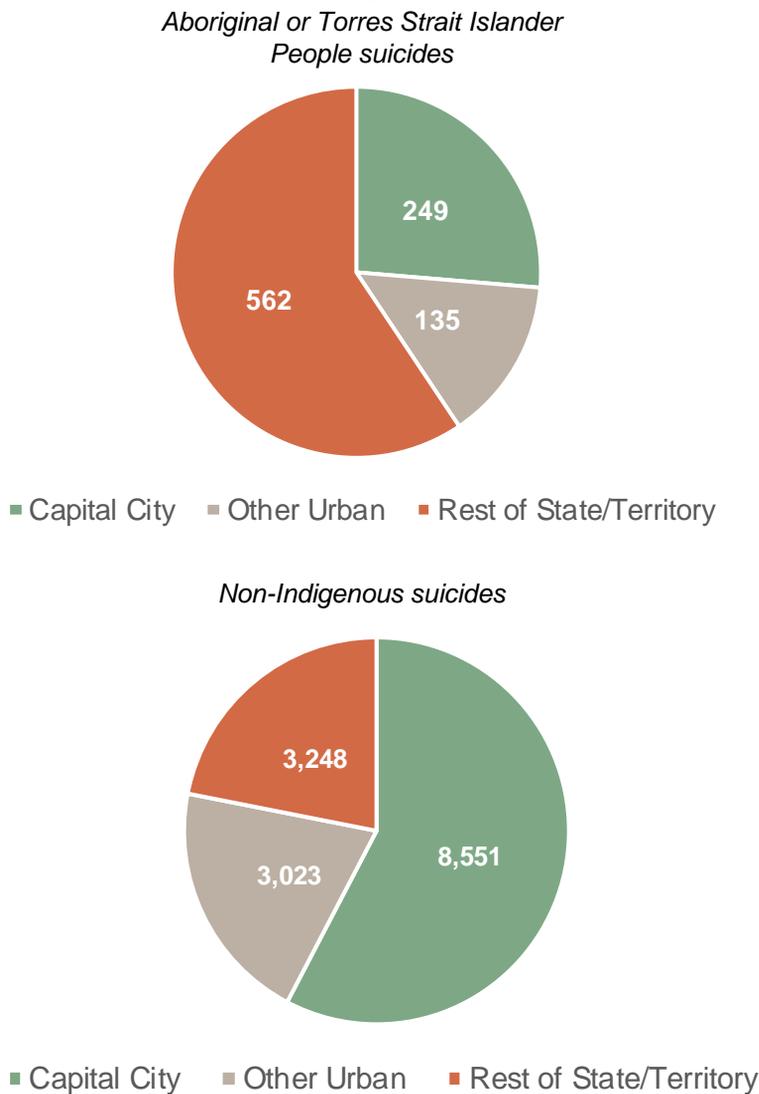
Cultural differences in rural suicide

The rate of suicide among Aboriginal and Torres Strait Islander people is much higher than for non-Indigenous people.

From 2001 to 2010, the standardised death rate for suicide among Aboriginal and Torres Strait Islander people was **22.3 per 100,000**. This was more than twice the rate for non-Indigenous Australians which was 10.3 per 100,000 (10). In 2015 the rate disparity has continued with rates of 25.5 and 12.5 respectively. (9)

In the same period (2001-2010), the majority of suicides among Aboriginal and Torres Strait Islander people **occurred outside of capital cities**. This is in complete contrast to non-Indigenous suicides, the majority of which occur within the capital city (based on data from NSW, Qld, SA, WA and NT). (10)

Graph 3: Number of Aboriginal or Torres Strait Islander suicides vs. non-Indigenous suicides 2015 (9)



7. Suicide by Aboriginal and Torres Strait Islander People

In 2016, the Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project (ATSISPEP) (11) released its final report, which highlighted that efforts to reduce suicide in Indigenous people must do more than address social and economic disadvantage, and narrow the gap in health status. “Upstream” strategies must be included that promote **healing** and building the **resilience** of “*individuals, families and communities by strengthening social and emotional wellbeing and culture*”.

“A common success factor in community-based interventions or responses to Indigenous suicide is their development and implementation through Indigenous leadership and in partnership with Indigenous communities. This is not only because responses need to address cultural and ‘lived experience’ elements, but also because of the right of Indigenous people to be involved in service design and delivery as mental health consumers. In addition, the empowerment of communities is a beneficial outcome in itself, with a potential for multiple flow-on benefits. With community ownership and investment, such responses are also likely to be sustained over time.” (11)



Things to think about

The prevention of suicide in rurally-based Aboriginal and Torres Strait Islander People needs to be a key focus of the prevention of suicide in rural Australia.

How do we develop a strategy that **enables, encourages and supports Indigenous leadership of approaches** to reduce Indigenous suicide?

Can we be brave enough to plan to **close the gap in Indigenous suicide rates** within one or two generations?



8. The Research

Not enough evidence

Apart from population data about suicide deaths, there is little epidemiological research specifically about rural suicide. Many studies into the risk and protective factors for suicide have not included an adequate rural sample. Planning and policy making is informed by studies conducted in densely populated areas. When planning for the prevention of rural suicide an assumption needs to be made that these research findings will be applicable in rural areas.

Further many, but not all, studies conducted in rural areas do not make a comparison to urban populations. Similarly there are fewer studies of interventions in rural areas compared to those undertaken in major cities.

“It is clear that although there is a strong interest in understanding rural suicide, and despite many coordinated efforts toward its prevention, the field of suicidology still has a great deal to learn about the phenomenon of rural suicide”. (12)

Are farmers the most at risk group?

Much has been written about suicides by farmers. Nevertheless it is difficult to draw any firm conclusions from the combined findings of the authors because of the inconsistent way in which the occupation of ‘farmer’ is defined. Is it the person who owns a farm, a person who manages a farm, a person who works on a farm, a person whose livelihood depends on farming? etc.

A recent paper by Alison Milner and colleagues (13) analysed previous studies about suicide rates in various occupations. While they did conclude that “Significantly elevated risk was also apparent in farmers and agricultural workers” they also commented on the limitations of their paper:

“There was also a large amount of heterogeneity between studies, which is likely because of inherent differences in how occupation was defined and classified, as well as connected to variation in when the study was conducted, and the social and geographical context of the study.” (13)

It is quite possible that rural suicide is a problem across other occupational groups in rural areas, particularly those which involve lesser-skilled occupations, seasonal workers, and itinerant workers.

Various rural industry leaders have approached the Centre for Rural and Remote Mental Health (the “Centre”) concerned about the welfare of their workforce. These include Department of Primary Industries, Local Land Services, stock and station agents, and stockyard owners and managers.

The stressors identified by the farm-related industries, are the exposure of their staff to stressed farmers and landowners, when these are affected by natural and man-made adverse events. The issue of having to meet with farmers to raise issues of non-compliance with laws and regulations is particularly stressful.

The Centre has also received requests for advice and training from mine and quarry owners and managers, concerned about the incidence of both mental illness and suicide among their workforce.

A further complication is that many farmers and their family members have more than one occupation. For example, some farmers operate a quarry on their land to supplement the income from farming.

8. The Research

Is poor help-seeking by rural men the main problem?

The answer to this is probably 'yes' but is also possibly 'no'. The main difference between rural and urban-living men may lie more in how they ask for help and from whom they ask for help.

Researchers from Griffith University looked at the Coroners' records for male suicides in Queensland from 1990 until 2012. They looked specifically at whether, or not, the files showed that the person who died had told anyone of their intention to take their own life. Telling someone is a form of help-seeking in that it could indicate that "I need help" rather than "I need a service to help me". The researchers concluded:

"The current findings do not support the expectation that suicide among rural men in Queensland would be characterised by lower levels of communication of suicidal intent than suicide among men in major towns." (14)

The implication of this is that the provision of gatekeeper training needs to be rolled out to those occupational groups to whom a farmer may express suicidal intent.

This research also indicates that the appropriateness and effectiveness of health services which rural men are accessing needs to be a key priority in efforts to reduce rural suicide.



Things to think about

How do we develop approaches that **balance the needs of different occupational groups and demographic sub-groups** in rural and remote areas?

How can we incentivise an investment in collecting the type of data that will shed light on **who exactly is most at risk of suicide** in rural areas?



9. The Road Ahead

Prevention now and for the future

The public health approach to prevention of an illness or disease is to look at the problem in three ways: primary, secondary, and tertiary prevention. It embraces interventions that prevent death and suffering now and into the future.

A public health approach to the prevention of suicide

Primary prevention of suicide would look at those risk conditions and protective factors that have been shown to be associated with a higher risk of becoming suicidal. Examples of potentially modifiable determinants are outlined in Figure 4.

Figure 4: Modifiable protective factors in primary suicide prevention

Individual	<ul style="list-style-type: none">• social and emotional learning, positive peer relationships, school connectedness, safe alcohol use, health literacy (especially about mental health and suicide)
Family	<ul style="list-style-type: none">• positive parenting, safe domestic environment
Social	<ul style="list-style-type: none">• supportive school and workplace environments, safe neighbourhoods, socially inclusive society
Economic	<ul style="list-style-type: none">• income security, safe housing
Environmental	<ul style="list-style-type: none">• stable and sustainable land and water use practices

Things to think about

While there is no evidence for the impact on suicide rates for the primary prevention of suicide, it is logical that **creating better social and economic conditions for individuals, families and communities would be a beneficial longer-term approach to suicide prevention.**

Which of the factors above would you think are most important for rural suicide prevention?

Who should be involved in leading, planning and implementing a long-term primary prevention strategy to reduce rural suicides?

How can government, non-government, industry and community sectors work together to take a collective approach to improving the health and mental health of rural communities?



9. The Road Ahead

Secondary prevention of suicide would look at identifying those individuals who are at higher risk of becoming suicidal either because of what has happened to them, or because of their own current behaviour (e.g. self-harm, risky drinking). Once identified, these individuals can then be provided with interventions that would lower their risk and increase their resilience.

For example, people in their childhood who have experienced chronic and, or painful illness, and those who experience trauma, loss or abuse, are more vulnerable to mental health problems and suicidality. Identified individuals must be provided with the support they need to address the psychological vulnerability of having been exposed to these conditions.

Things to think about

There are many government, non-government, charitable and community services that provide support to those whose social, health, or economic circumstances place them at a higher risk of suicide in the near or long-term future.

Is it possible that these service providers could also build in interventions to increase the resilience of the people they support?

Who could lead the identification, design and evaluation of **resilience-building** programs for those who are vulnerable to future suicide risk?



We also need to encourage such individuals to recognise the signs of distress in themselves, and to ensure that they know what steps they can take to reduce distress and what services, programs and resources are available to assist them.

There are a range of programs to raise the community's awareness of and knowledge of the issues of mental illness and suicide. However, an issue affecting people in remote and very remote rural areas is the limited range of support services available to people at risk of future mental health problems, which is not adequately addressed currently by on-line information, advice or therapy.

This limitation is further affected by the lack of choice available in terms of services for people who have difficulty accessing mainstream services such as (for examples, Aboriginal and Torres Strait Islander People and LGBTI people).

Things to think about

How can our efforts to provide information and to raise awareness be made relevant to rural areas?

How can local communities become better informed and more easily informed, especially about the choices available to them when they experience distress?



9. The Road Ahead

Tertiary prevention of suicide would involve linking up those who are contemplating suicide, those who are engaging in active self-harm, and those who have made a suicide attempt, to the supports and services that will help them to avoid further attempts or death by suicide.

In the short-term our efforts to lower the suicide rate needs to focus on those who are at current risk of suicide attempts. The nine strategies outlined in the NSW Mental Health Commission's Proposed Framework for Suicide Prevention and the Black Dog's LifeSpan Project provide examples of tertiary prevention.

Some thought will need to be given as to how these nine strategies can be implemented, particularly in outer regional, remote and very remote areas.

Stark and colleagues 2016 (15) have identified other possible approaches, including broadening the type of occupational groups who may play a gatekeeper role.

“It is likely that the accessibility of community-based services (other than health services) may be of importance to rural suicide prevention. Individuals who hold key positions in rural societies, such as employers, community leaders, or clergy, may have a gatekeeper role to play in identifying those at high risk and directing them to appropriate supports or services” (15)

Things to think about

How can we implement **evidence-based tertiary prevention strategies** in rural and remote communities areas?

How can we address the challenges for current service providers who may not have an **adequately trained workforce** to deliver necessary services?

Who should be involved in developing a strategy to solve **the gap in quantity and quality of services** available in rural areas?



10. Concluding Remarks

It is evident from this Briefing Paper that rural suicide prevention is as complex as it is important to our society. However, without considering what needs to be different for *'rural'* in the context of suicide prevention, it is unlikely that a meaningful impact on the nation's suicide rates will occur.

The intent of this paper was to provide you with the necessary background information and to encourage your thoughts on what needs to be different. The Forum on the 11th of April 2017 will be a day to hear expert stakeholders' perspectives on rural suicide prevention and to share your thoughts. More importantly, it will be a day to stimulate action and have a focused conversation on this issue.

The Centre looks forward to this discussion on the 11th of April and to engaging in an ongoing partnership with stakeholders to put the prevention of rural suicides on to the agenda.



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