



Suicide Prevention
Australia

POSITION STATEMENT
Social Inclusion and Suicide Prevention
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About Suicide Prevention Australia

Suicide Prevention Australia Inc. (SPA) is the national peak body for the suicide prevention sector. SPA is a not-for-profit organisation representing a broad-based membership of organisations and individuals with a commitment to suicide prevention. SPA works to prevent suicide by supporting its members to build a stronger suicide prevention sector; developing collaborative partnerships to raise awareness and undertake public education; and advocating for a better policy and funding environment.

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Position statements are not intended to be specific to or limited to policy makers alone, but are instead written with a general cross section of the educated lay public in mind (i.e. broader community, media, and other non government organisations). SPA Position Statements therefore represent a starting point for policy and strategy development, while supporting SPA's ongoing advocacy work and activities.

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Social Inclusion and Suicide Prevention

Social Inclusion and Suicide Prevention Guiding Principles

- Social inclusion emphasises community wide social participation, integration, cohesion and access to connections.
- Social inclusion has positive implications for the health and welfare of communities.
- The social inclusion approach is emerging as a framework for tackling mental illness and disadvantage with subsequent potential to prevent suicide.
- Suicide prevention requires a progressive approach to social inclusion which addresses marginality and assertively tackles disadvantage.

Introduction

Social exclusion is characterised by social isolation, a lack of connections and unequal access to resources – all known risk factors for suicide. This position statement reviews the literature examining social inclusion and its relevance and implications for suicide prevention.

First, it will examine the concept and definitions of social inclusion and social exclusion, and their place in Australia's social policy agenda. Second, it will critically explore current research on what the various dimensions of social inclusion offer for further understanding the risk and protective factors of suicide, suicide ideation and suicidal behaviour. Finally, it will examine the use of a social inclusion approach to suicide prevention.

While current research does not yet offer definitive evidence to provide clear direction in developing social inclusion as a suicide prevention strategy, there are encouraging initiatives and studies which provide a strong rationale for further development of this approach to suicide prevention.



Social Inclusion and Social Exclusion: What Do They Mean?

The social inclusion model is an emerging theoretical framework for approaching mental illness, social exclusion and disadvantage (Queensland Alliance 2010; Long 2010). Social inclusion is multidimensional, incorporating economic, political and social dimensions and emphasising equality of opportunity, human rights and participation.

It is not just about including those who are marginalised; social inclusion strives to break down the barriers to social participation and tackle the aspects of society that permit and sometimes foster the exclusion of others. Viewed broadly, social inclusion is a process that does not take place at the individual level, but at a social level and is closely related to social environments (Atkinson 1998). There is no universal definition of society or community and social inclusion incorporates a progressive and inclusive approach rather than seeking to delineate differences.

Social exclusion has traditionally been viewed as synonymous with poverty and is usually linked to participation in the market economy. However an emphasis on social participation, integration, cohesion and access to connections is becoming more dominant, with relevance for mental wellbeing and suicide prevention. Despite social exclusion being a relative and contested concept, Levitas et al. (2007) offer the following definition which captures general thinking about social exclusion:

Social exclusion is a complex and multi-dimensional process. It involves the lack or denial of resources, rights, goods and services, and the inability to participate in the normal relationships and activities available to the majority of people in society, whether in economic, social, cultural or political arenas. It affects both the quality of life of individuals and the equity and cohesion of society as a whole (Levitas et al. 2007 p. 9).

In Australia, definitions of social exclusion focus on lack of connectedness, the multidimensional features of exclusion and the implications of the social and physical environments in which individuals live (Silver 2010). Undertaken in 2006,

the Community Understanding of Poverty and Social Exclusion (CUPSE) survey identified three forms of social exclusion in Australia:

- disengagement: lack of participation in social and community activities
- service exclusion: lack of adequate access to key services when needed
- economic exclusion: restricted access to economic resources and low economic capacity.

The prevalence of social exclusion can, in part, be measured by relative socio-economic disadvantage, health, education and labour status and participation in key activities. The CUPSE survey compared respondents concluding that there were significant differences in the severity of deprivation experienced across socio-economic groups with those on welfare, Indigenous Australians and sole-parent families socially excluded across a variety of indicators (Saunders 2007a; Saunders 2008). Those indicators which showed greatest relative deprivation were those which impacted mostly on children and their social and community participation. Such indicators can have long-term consequences for their development and welfare (Saunders 2007b).

The Australian Approach to Social Inclusion

The development of the discourse on social inclusion led to growing attention among Australian policy makers and researchers. The political impetus for social inclusion policy began in South Australia in 2002 under Mike Rann's Government. The South Australian Social Inclusion Initiative is 'about participation; it is a method for social justice. It is about increasing opportunities for people, especially the most disadvantaged people, to engage in all aspects of community life' (Government of South Australia 2006).

This initiative was followed by former Prime Minister Kevin Rudd's creation of a Ministry for Social Inclusion, Australian Social Inclusion Board and other posts dedicated to achieving an 'inclusive Australia'. Importantly, this led to the development of the Commonwealth Government's national agenda and framework for action on social inclusion, *A Stronger, Fairer Australia* (2010). This framework aims to address the issues identified in the CUPSE survey, namely disengagement and service and economic exclusion. The preliminary priorities of this approach include opportunities for: securing a job; accessing services; connecting with others in life through family, friends, work, personal interests and local community; dealing with personal crises; and being heard (Hayes, Gray & Edwards 2008). The Australian Government social inclusion agenda is thus built on the four pillars of opportunity and capability for all residents to 'learn', 'work', 'engage' and 'have a voice'.



Besides South Australia, other Australian states and territories are designing and implementing policies targeting social inclusion (Cappo 2010; Gray & Bresnehan 2010). The Victorian Government's framework, *A Fairer Victoria*, addresses disadvantage and strives to create opportunities, particularly for Indigenous Australians, those with mental health problems and refugees (Burns 2010). The Victorian social inclusion approach to mental health recognises the link between social connectedness and the social determinants of mental illness.

In addition, there are national priorities for social inclusion in areas of employment participation for jobless families, health, homelessness, and child poverty (Silver 2010; Buckmaster & Thomas 2009). In particular, a number of social inclusion policies are currently being trialled in Indigenous communities (Hayes, Gray & Edwards 2008). Several community-based organisations, including the Brotherhood of St. Laurence, the Smith Family, Mission Australia and Anglicare have implemented social inclusion programs and explicitly adopted social inclusion frameworks to address homelessness (Barnett 2010; Chambers 2010; Pate & Cull 2010).

Executive Director of the Brotherhood of St. Laurence and Social Inclusion Board member, Tony Nicholson, proposes the following approach to social inclusion in Australia:

A social inclusion approach involves the building of personal capacities and material resources, in order to fulfil one's potential for economic and social participation, and thereby a life of common dignity (Barnett 2010 p. 21).

According to Buckmaster and Thomas (2009), with the Australian emphasis on social participation, social inclusion bears resemblance to the concept of social citizenship. They also argue that social inclusion needs to be strengthened by creating a more active and participatory approach to social arrangements, rights, responsibilities, citizenship and quality (Buckmaster & Thomas 2009; Queensland Alliance 2010).

Social Inclusion and Suicide: What the Evidence Tells Us

As with the concepts of 'social inclusion' and 'social exclusion', there are conceptual and ideological confusions, disagreements and differences in the research literature in regards to a framework for suicide risk and protective factors. However, the link between indicators of social exclusion, such as socio-economic disadvantage, social fragmentation, unemployment and inequality and suicide, have been well established (World Health Organization 2011).

Social environments have been linked to suicide prevention since the work of Durkheim, who explored the link between health and social integration. Expanding on Durkheim's work, the twin concepts of social capital and social connectedness can be considered to inform and be found under the broader concepts of social inclusion and suicide prevention.

To support Australian's access to social capital and strengthen their social connectedness, the Australian Government's social inclusion agenda incorporates the four pillars of 'learn', 'work', 'engage' and 'have a voice'. While not specifically targeting suicide prevention currently, the potential of these pillars to have a positive impact on individual wellbeing and thus reduce vulnerability to suicidality shall be explored below.

Social Capital – Learn and Work

Although social capital has a number of definitions, it is generally conceived of as including the existence of community networks, civic engagement, civic identity, reciprocity and trust (Kunitz 2004; Kushner & Sterk 2005; Braswell & Kushner 2010; Williams & Galliher 2006; Helliwell 2004; Putnam 1995). The relationship between social capital and health, including mental health, is well established (Cullen & Whiteford 2001; Kunitz 2004; Helliwell 2004; Islam et al. 2006). Applying social capital theory to the field of public health, Szreter and Woolcock (2004) propose that social capital provides capabilities for 'bonding', 'bridging' and 'linking'. Bonding refers to the ability for people to trust and form cooperative relationships with people with whom they share common social norms and can be considered 'getting by'. Bridging refers to the ability for people to build respect and reciprocity with those who are unlike them but relatively equal in status and can be considered 'getting up'. Linking refers to the ability to build relationships with those in positions of power or authority for personal benefit and resources and can be considered 'getting ahead'. While not infallible, relative access to social capital and thus health status can be considered along this continuum of 'getting by', 'getting up' and 'getting ahead'. Taken broadly, determinants of mental illness and suicide risk are similarly weighted in this continuum.



The building of social capital in modern society begins, but by no means ends, with the functions of learning and working. Individual and collective education levels are an important predictor of capability for social engagement and access to social capital (Helliwell & Putnam 2007). Education levels tend to correlate with social trust ('bonding' and 'bridging') and political engagement ('linking'), while simultaneously increasing access to working opportunities. Employment provides meaningful activity, opportunities for building social connections and access to the material

requirements for active social participation and positive health and wellbeing. Unemployment is associated with two to three times increased risk of suicide, compared to being employed, partly confounded by mental illness factors (Blakely et al. 2003). Education and employment alone promote rather than ensure individual or collective wellbeing, but in addition, they increase opportunities for health and social capital by facilitating self-determination and empowerment.

Marmot (2006) describes empowerment as the second tenet of health improvement (the first tenet being material conditions). Empowerment in this sense is removing the focus of social inequality from what a person has, to what they can do with what they have (Marmot 2006). This approach is often absent in social inclusion policy and is a challenging but important goal. Empowerment and self-determination are important for individual wellbeing, especially for those who are disadvantaged. Supporting this hypothesis, Williams and Galliher (2006) found social connectedness is the mediating link between social functioning and wellbeing. Social connectedness, as a dimension of social capital, is described as a global view of the self in relation to others, and is considered to be the ability to connect, rather than the availability of connections. Social connectedness is a stronger predictor of psychological wellbeing and thus suicide protection than even the accessibility of social support (Williams & Galliher 2006). Social connectedness develops in correspondence with the development of a young person's view of the world and them in it, and is thus related to education and socialisation.

Taking this approach, the principles of increasing social capital and achieving social inclusion are centred on empowerment and autonomy, and on assisted access to education and employment while simultaneously allowing self-determination and self-empowerment. The benefits include increased resilience, access to resources and support and mitigation of social determinants of mental illness; thus increasing the protective factors for suicide. The achievement of this in practice is complex and closely related to the successive pillars of 'engage' and 'have a voice'.

There is a growing body of evidence showing a positive relationship between social capital and good mental health (Cullen & Whiteford 2001; Kunitz 2004; Helliwell 2004; Islam et al. 2006). A study by Lee et al. (2001) using social capital surveys, show that a higher sense of social capital is correlated with more socially-active individuals, easier engagement in relationships, and perceptions of others in a more positive way, all of which correlate with wellbeing.

Of particular relevance to suicide prevention and mental health, is social capital which facilitates access to services when necessary. The CUPSE survey results showed that 38% of Australian welfare recipients have no access to mental health services when required, and 60% had no access to disability services, while the general community had similar high rates at 25% and 50% respectively (Saunders 2007b). The survey results indicate that limited social capital in this sense is a consequence of multiple levels of exclusion including economic and social factors.

Helliwell's (2004) analysis of data from 117 surveys from 50 countries covered by the World Health Survey and the European Values Survey shows a strong correlation between the different dimensions of social capital and suicide. The results show that more social capital and higher levels of trust are associated with lower national suicide rates and higher levels of well-being.

Kelly et al. (2009) examine the relationship between social trust, as a dimension of social capital, and national suicide rates in 11 European countries. After controlling for gender, age, marriage rates, incomes and reported sadness, the authors found a positive relationship between higher social trust and lower suicide rates. Stewart-Withers and O'Brien (2006) stress the importance of considering the local and cultural context of social capital as a strategy for suicide prevention. The authors, studying suicide rates in Samoa, argue:

Any approach to suicide prevention needs to actively consider the community it is meant to represent, reflect the values and beliefs of the culture, and occur in partnership with the community. Without the cooperation of the 'grass roots' community, mental health promotion and suicide reduction strategies are unlikely to be successful (Stewart-Withers & O'Brien 2006 p. 209).

Although the evidence offered by the existing research literature is not robust or comprehensive, generally there does appear to be a positive relationship and association between social capital and suicide prevention. However, further research needs to address the limitations of both this existing literature and the social inclusion model.



Belongingness – Engage and Have a Voice

Social capital and social connectedness enable and foster a person's ability and desire to belong to a community or society that values their contribution. Community belonging makes people feel cared for and valued which protects their wellbeing (VICSERV 2008). The absence of belongingness leads to vulnerability, isolation, alienation, loneliness and a lack of support; all known risk factors for suicide.

Belonging is the essential component of self-value and self-esteem that comes from being an active member of a group or relationship. Closely related to social connectedness, belongingness comprises not just in passive participation in individual interactions, but in long-term capabilities and access to opportunities for meaningful engagement with others, including having a voice in group decisions. Achieving social inclusion through engagement and providing avenues for citizens to have a voice is complex and relatively sidelined in social inclusion policy. Yet the potential for these pillars of social inclusion to promote belongingness and protection against suicide is evident.

Engaging and contributing to community and civic activities has social and psychological benefits for young people (Australian Institute of Health and Welfare 2007). Making a difference in the lives of others significantly reduces the risk of suicide ideation in youth (Elliott et al. 2005), while increasing meaningful participation in social and civic community life across the lifespan reduces social exclusion and leads to improved wellbeing and quality of life (Baum 2000).

According to a review of the empirical literature on risk factors by Van Orden et al. (2010), 'social isolation is arguably the strongest and most reliable predictor of suicide ideation, attempts, and lethal suicidal behaviour among samples varying in age, nationality, and clinical severity' (p. 579). The majority of callers to Lifeline's crisis service, express loneliness and social disconnection is the primary or intermediary factors in their distress, even though many are living with others (Lifeline 2011). Of those calls that relate to suicide, 33% report 'aleness and (lack of) support' as the secondary factors to their suicide ideation (ibid). In addition to a lack of support, social isolation is manifested by a thwarted fundamental psychological need: the need to belong (Baumeister & Leary 1995).

Thomas Joiner's interpersonal theory of suicide proposes that the need to belong is the specific interpersonal need involved in suicidality (Joiner 2005; Van Orden et al. 2008; and Van Orden et al. 2010). Thwarted belongingness is a multidimensional concept, made up of two principle elements: loneliness and the absence of reciprocal care. Under these two elements, are observable indicators such as lack of family support, social withdrawal or relationship problems, all which are associated with elevated risk (see Van Orden et al. 2010, p. 581). Joiner's theory suggests that suicide prevention targeting these elements may be effective and public health campaigns promoting the importance of maintaining meaningful social connections and social contributions could impact on suicide rates.

Researching belongingness, Twenge et al. (2002) found the need to belong produced an assortment of self-defeating behaviours that exposed individuals to further risk. 'At the very least, our results suggest that a strong feeling of social inclusion is important for enabling the individual to ... protect the self and promote the self's best long-term interests of health and well-being' (p. 614).

A 2011 study of individuals with substance abuse disorders shows that belongingness, perceived social support, and living alone were significant predictors of suicide attempts (You & Van Orden 2011). Barstad's (2008) examination of the changing suicide rates in Norway between 1948 and 2004 points to a weakening of family integration, particularly through substance abuse, as the most significant factor associated with increasing suicide rates. Gunnell et al. (2003) also highlight the importance of changing relationship patterns and social integration at the interpersonal level (the need to belong) for reducing the suicide rates among young men. Qin et al.'s (2003) study of all suicides in Denmark between 1981 and 1997 show that single marital status is the most significant risk factor for male suicides in terms of population attributable risk.

Yur'yev et al. (2010) assess the national attitudes towards the elderly and their association with elderly suicide mortality in 26 European countries. Their results indicate that the elderly are prone to be affected by levels of social and family integration and societal attitudes. Suicide rates are lower among elderly people in countries where elderly relatives live with the family. They postulate that 'enhancing elderly people's social inclusion could be highly beneficial in terms of mental health' (p. 1341). There is also a strong correlation between longer participation in employment and suicide rates. This is found across different age groups and countries (Yur'yev et al. 2010; Van Orden et al. 2010).

Kaminski et al. (2010) analyse the comparative strength of different domains of family, peer and school connectedness, using US health survey data for adolescents. Their study suggests that family disconnectedness was a stronger predictor than peer or school for non-suicidal self-harm, suicidal ideation, suicide plans, and non-fatal suicide behaviours. In a survey of 212 adolescents, Matlin, Molock and Tebes (2011) find similar results suggesting that increased family and community connectedness protect against suicidal behaviour. Within a national sample of data from the US, Winfree and Jiang (2010) found that extensive parental support alone among the parent-related factors reduced both suicide ideation and attempts. 'That is, adolescents who felt parental love and caring were less likely to think about suicide or attempt it than those not reporting such bonds to parents' (pp. 30–31). Family connectedness and support can mitigate the negative effects of other forms of social exclusion such as discrimination.

Although individual interpersonal connections may be strong, there often remains an overarching need to belong to and engage with the wider community. This can be threatened in situations of overt social exclusion. Groups recognised to be at high risk of suicide¹ – Indigenous, sexual minority, mentally ill, rural and remote, refugee, drug and alcohol affected and socio-economically disadvantaged communities – often suffer from various forms of social isolation and exclusion (Lifeline Australian & Suicide Prevention Australia 2010; Van Orden et al. 2010; Cvinar 2005; Barstad 2008). Individuals may suffer social isolation due to their inability to socially participate, or social isolation may be inflicted on them through ostracism, rejection, stigma, bullying, disrespect or prejudice (Silver 2010). The former is linked to empowerment and engagement, while the latter is a direct form of discrimination. For example, the links between discrimination and suicide risk in the gay, lesbian, bisexual, transgender and intersex (GLBTI) community have been well documented (Hass et al. 2011), and severity of discrimination correlates with the severity of suicidality (Hillier et al. 2010).

Research shows that bullying and direct exclusion of children increases likelihood of depression and suicide ideation among those who are bullied and their bullies (Kim 2008). Although the relationship between bullying and suicide is unclear and may be influenced by mediating factors, the availability of social support for victims and perpetrators of bullying decreases their vulnerability to mental health problems. School inclusion programs which promote social support and belongingness may be the most effective ways of reducing bullying and its negative impacts.

¹ Please refer to the following Suicide Prevention Australia position statements for more information on groups recognised to be at risk of suicide:

Suicide Prevention and Capacity Building in Australian Indigenous Communities

Responding to Suicide in Rural Australia

Mental Illness and Suicide

Suicide and Self Harm Among Gay, Lesbian, Bisexual and Transgender Communities



Discrimination is primarily tackled by increasing knowledge and removing prejudice through education and contact measures, reinforced by legislation and protest elements. The involvement of those who are excluded in these anti-discrimination measures ensures efficacy but also provides a voice for isolated individuals and groups.

The formulation of these policies cannot be accomplished behind the closed doors of government. Social inclusion is an active relational process. To rebuild social bonds, participation of all citizens, especially excluded groups, in designing, executing, and monitoring policies is a prerequisite to social inclusion (Silver 2010 p. 205).

Overall, the existing literature suggests the importance of belongingness as a conduit to social inclusion, but still leaves further research to be pursued on the strength of various domains as protective factors for suicide.



Social Inclusion as Suicide Prevention Policy

The Commonwealth Government's Department of Health and Ageing LIFE framework (2007) embodies many aspects of Australia's social inclusion agenda such as social connectedness, social cohesion, membership, belonging and social integration. These aspects of social inclusion often form the basis for community suicide prevention measures, which target specific risk factors such as drug and alcohol issues or rural and remote communities.

However, a social inclusion approach has not been comprehensively applied to suicide prevention. Currently, suicide prevention measures inevitably focus on those risk factors with observable correlations and measurable suicide prevention outcomes, which the social inclusion discourse still lacks.

Although research has consistently shown that there is no discrete set of characteristics or circumstances that determine suicidal ideation and/or behaviour, mental health problems are a major risk factor in Australia and elsewhere (Lifeline Australia & Suicide Prevention Australia 2010). The social inclusion model is an emerging framework in mental health (Queensland Alliance 2010). This model is currently the leading social inclusion approach to suicide prevention.

The social inclusion approach to mental health takes on many of the elements as defined by the broader social inclusion agenda including: focusing on fostering connections with people; engendering greater participation and citizenship; promoting a client-centred approach; addressing the social, economic and political dimensions of social exclusion; and conceptualising the role of government and communities to reduce barriers to social inclusion that limit the opportunities of at risk groups.

The social inclusion approach to mental health is often focused on employment and social factors, both of which can contribute to reducing suicide risk, especially considering the independent benefits that these measures can have on mental health. In 2010 the Federal Government announced a Taking Action to Tackle Suicide package, which pledges support for non-clinical as well as clinical services for those at risk of suicide and which recognises the social determinants of wellbeing. Other initiatives such as Men’s Sheds, the Personal Helpers and Mentors Program and other peer support programs aim to assist those at-risk to participate fully in society. Social determinant approaches to mental health – especially those focused on early childhood, life stage transitions and reducing disadvantage – may have further potential to benefit from the expansion of the social inclusion agenda.

The World Health Organization (WHO) promotes social capital and inclusion to increase healthy behaviours, provide access to services and develop protective psychosocial practices to prevent mental illness and suicide (Whiteford et al. 2005). WHO designed and implemented a social inclusion pilot approach to mental health reform in the Russian Federation (Jenkins et al. 2007). Evaluation data showed positive results for the health status of clients and professional practice standards.

The 2010 Queensland Alliance report on anti-stigma and discrimination initiatives in mental health posits that a social inclusion approach ‘delivers an elegant framework for integrating rights-based approaches, moving away from seeing stigma as a health-based issue, recognising essential determinants of health and ways of promoting a mentally healthy society’ (p. 17).

The Psychiatric Disability Services of Victoria (VICSERV) posit social inclusion as a necessary but currently absent element of mental health care, stating:

It is time for a new agenda that fundamentally shifts and shares efforts to building socially inclusive communities in which people living with serious mental illness are effectively supported to engage and participate in society (VICSERV 2008p. 17).

The Social Inclusion Suicide Prevention Initiative in Country South Australia drew on the LIFE Framework to inform its inclusive, multi-sectoral and participative approach to suicide prevention in Indigenous communities (Government of South Australia 2007; Stacey et al. 2007). Results from this initiative indicate a positive approach to mental health promotion for suicide prevention when there is a focus on resilience, coping strategies, wellbeing and positive personal and cultural identity. It also suggests that involving young people as active participants in the program and decision-making process is critical, and should not be based on pre-determined agendas such as employment pathways (Government of South Australia 2007). Although there is a lack of empirical evidence demonstrating the effectiveness of this initiative, survey results show that respondents felt that inclusive, community partnerships made ‘a fair bit’ or ‘a lot’ of difference (Stacey et al. 2007).



In addition to mental health factors, a social inclusion approach has potential to benefit suicide prevention when it targets the institutional and social barriers to the full participation and acceptance of marginalised groups. The higher suicide risk for Indigenous, GLBTI, elderly and culturally diverse communities is, in part, mediated by the real or perceived stigma and exclusion that they experience from the wider community. Such stigma and exclusion is fuelled by political, historical, religious and social factors. Measures to overcome individual and institutional discrimination and prejudice have the potential to provide increased equality of opportunity and acceptance, and reduce bullying and persecution, thus lowering suicide risk. While some programs have been instigated (such at the Closing the Gap initiative) and progress is hopeful, evaluation data doesn’t yet provide strong evidence of impact on mental health.



Overall, there is a lack of research and evidence on a social inclusion approach to suicide prevention. However, there is encouraging evidence from the research literature that demonstrates relationships between some elements of social inclusion and suicide, suicide ideation and suicidal behaviour.

Moving Forward

Taking a social inclusion approach to suicide prevention has the potential to refocus efforts on the social determinants of suicide, while maintaining and bolstering investment in those at high risk. Elements of social inclusion such as social capital and social connectedness have positive implications for the social and emotional wellbeing of all community members, especially those who are disadvantaged. Investments in these approaches can break the cycles of disadvantage which predispose individuals to risk of exclusion, mental health problems and suicide.

The Social Inclusion Annual Report 2010 from the Australian Social Inclusion Board proposes the following principles to tackle disadvantage, exclusion and their outcomes:

1. understand the psychological impact of social disadvantage, avoid reinforcing hopelessness
2. provide practical support that is flexible, tailored and accessible
3. ensure long-term support rather than a focus on crisis.

In comparison to providing individual reactive approaches, community-based social inclusion and participation measures provide inexpensive, efficient and administratively straightforward methods of increasing social cohesion (Berry 2008). A focus on the social and economic determinants of mental health shall have positive implications beyond that of reduced incidents of mental illness and suicide but extend to physical health, education, employment, family and community benefits (Walker et al. 2005).

Investing in social capital as a means of promoting mental health and preventing suicide is a life course approach which requires macro social policy reform while simultaneously increasing family and community capacities (Whiteford et al. 2005). Such macro policy reform remains elusive in the current policy sphere, but emerging evidence and micro policy changes are contributing to an increased emphasis on social inclusion as a mainstream general health and suicide prevention ideology.

Community measures to promote social inclusion include community development initiatives to provide avenues of integration and support for people. Such measures include:

- neighbourhood social activities
- employment services
- child development initiatives
- crisis support services including face-to-face contact, phone and online support
- drug and alcohol services and other community support.

Social inclusion and suicide prevention are linked in direct and indirect ways, most simply through the social and emotional benefits that social connectedness and belonging create. Social inclusion and suicide prevention measures deserve increased policy attention and integration.



Recommendations

Suicide Prevention Australia makes the following recommendations for social inclusion and suicide prevention:

- Further research is needed to widen the empirical basis of social inclusion as an approach to suicide prevention.
- The Australian Social Inclusion Agenda, as governed by the Australian Social Inclusion Board, should consider the merits of making suicide prevention a stated goal of social inclusion policy.
- The Australian Social Inclusion Board and all related policies should monitor and report against suicide prevention indicators such as suicide attempts and deaths, to mainstream suicide prevention into social inclusion policy.
- Australian suicide prevention policy should apply a social inclusion approach to targeting the social determinants of suicide, generating long term outcomes and protecting people from the trajectory towards suicidality.
- Engagement and empowerment are important features of social inclusion which require progressive policy mandates.
- Funding should be channelled to those initiatives and services that promote social cohesion and connectedness, the benefits of which are widespread.
- Explicit anti-discrimination measures which incorporate education, contact and protest measures should be developed and supported.
- Support for community suicide prevention, such as that included in the Taking Action to Tackle Suicide package, should mainstream the principles of social inclusion into the design and delivery of initiatives.
- Consistent and efficacious evaluation practices are required to monitor social inclusion and suicide prevention correlates.

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