

National suicide prevention strategy for Australia's health system: 2020–2023

A nationally agreed strategy to strengthen the response of health systems
as one part of a whole-of-government approach to suicide prevention



Front cover artwork

Reflections of Change: Riki Benton

I was born in Levin, New Zealand, I moved to Australia when I was 14. At age 22 I was involved in a serious motor vehicle accident causing a Traumatic Brain Injury. While learning to walk, talk again I began suffering some mental health issues. Over time I learnt that creation of art kept me in the present moment where I was able to express myself in ways I wasn't able to verbally convey. Creating artwork helps keep me focused and gives me tools to deal with my ongoing illness.

This particular Artwork represents a peaceful place I try to visualize myself in when I am not feeling too well. The bright colours of the water are the many emotions I feel, water comes and goes and the water flows, reminding me that just like the water things will always change colour, as with my mind.

The trees represented in the background is my recovery, where with the water, life continues to nurture and grow fresh new leaves.

This picture calms my erratic noisy mind, and the bright colours are a reminder to look for the light among the darkness.

Need help?

Thinking and reading about suicide can be distressing.

If you need help, please access the support you need. No one has to face their problems alone.

National 24/7 crisis services

Lifeline

13 11 14

www.lifeline.org.au

Suicide Call Back Service

1300 659 467

www.suicidecallbackservice.org.au

MensLine Australia

1300 78 99 78

www.mensline.org.au

Beyond Blue Support Service

1300 224 636

www.beyondblue.org.au

SANE Australia Helpline

1800 187 263

www.sane.org

QLife

1800 184 527

www.qlife.org.au

Kids Helpline

1800 551 800

www.kidshelpline.com.au

National Alcohol and Drug Information Service

1800 250 015

www.counsellingonline.org.au

Gambling Help

1800 858 858

www.gamblershelp.com.au

Postvention bereavement support services

StandBy Response Service

0418 575 680

National Indigenous Critical Response Service

1800 805 801

If you or someone you are with is in immediate danger, please call triple zero (000).

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email Mental Health branch <MHBCoordination@dhhs.vic.gov.au>.

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Foreword

Suicide affects people of all ages and backgrounds. Too many lives are lost and too many people feel that their only option is to not go on living.

Suicide is a significant public health issue in Australia. It has a ripple effect that is long-lasting, far-reaching and deeply felt by individuals, families, communities and in schools, tertiary institutions and workplaces across Australia. We now understand how complex suicide is, and that it is preventable.

This is the first national suicide prevention strategy in Australia endorsed by Commonwealth and state and territory Health and Mental Health Ministers. Building on the directions of the *Fifth National Mental Health and Suicide Prevention Plan*, it commits all governments to working collaboratively on a journey towards zero suicides in Australia.

The strategy supports this journey by providing an anchor point for Commonwealth and state and territory suicide prevention priorities and strategies, and regional and local suicide prevention efforts. It describes the consensus reached by all governments on strategic directions, priorities for change, roles and responsibilities and how to strengthen system design and infrastructure.

This strategy also reaffirms each government's commitment to a whole-of-government approach to suicide prevention, where accountability for reducing suicide rates is shared across multiple portfolios and the three tiers of government. Whole-of-government approaches will mature as governments implement their priorities and strategies; and will be fully realised in Australia's next national suicide prevention strategy, to be endorsed by the Prime Minister, Premiers and Chief Ministers in 2024. This reflects the former COAG Health Council's agreement that suicide prevention is a national priority at its 9 August 2019 meeting.

The strategy's development brought officials from Commonwealth and state and territory health departments together with peak organisations, suicide prevention experts and people with lived experience of suicidal behaviour. The collective expertise and commitment of these people to prevent suicidal behaviour enabled a consensus on the actions outlined in the strategy being of the highest priority. The courageous stories of people with lived experience of suicidal behaviour remind us of the importance and urgency of this work, and their messages of resilience, hope and recovery are compelling.

Suicide is everyone's business. Working together we can build resilience, strengthen protective factors for preventing suicide and compassionately support those who need it, so they continue to lead a life worth living.



The Hon. Natasha Fyles MLA
Chair, Health Council



Acknowledgements

In memory

This strategy is dedicated to the people whose lives have been lost to suicide, to those who have considered ending their own life and to those bereaved by suicide.

Acknowledgement

This strategy acknowledges Aboriginal and Torres Strait Islander peoples as the first inhabitants of this nation and the traditional custodians of the lands where we live, learn and work. Governments pay respect to all Aboriginal and Torres Strait Islander Elders, past and present from every nation.

Building on the efforts of many

This strategy builds on, and furthers, the suicide prevention work that has taken place in Australia since the mid-1990s. This work has been led by many, including Commonwealth, state and territory governments of all persuasions, by health services and clinicians, by non-government organisations and peak bodies, by researchers, by people with lived experience of suicidal behaviour and by communities.

Preferred language

This strategy acknowledges the importance of safe and responsible communication about suicide. It has been drafted in line with the *National Communications Charter: a unified approach to mental health and suicide prevention*.

Contents

Need help?	iii
Foreword	v
Acknowledgements	vi
Executive summary	1
Introduction	4
Whole-of-government suicide prevention	11
About this strategy	13
Priority domains	15
Supporting individuals and communities to seek help and to support others	15
Building a system of care to change the trajectory of people in suicidal distress	23
Enabling recovery through post-crisis aftercare and postvention	34
Community-driven Aboriginal and Torres Strait Islander suicide prevention	43
Priority foundations	48
Building and supporting a competent, compassionate workforce	48
Better use of data, information and evidence	57
Government leadership that drives structures and partnerships to deliver better outcomes	63
Appendix 1: Existing strategies and frameworks	67
Appendix 2: Membership of the National Suicide Prevention Project Reference Group	68
Glossary	69
References	71



Executive summary

Tragically, 3,046 lives were lost to suicide in Australia in 2018 (Australian Bureau of Statistics (ABS) 2019a).¹ This is more than twice the number of Australians who died on our roads in that year (Department of Infrastructure, Regional Development and Cities 2018).

Suicide is one of the greatest preventable public health and social challenges of our time. The *Fifth National Mental Health and Suicide Prevention Plan* (the Fifth Plan) recognises the profound impact of suicide on the lives of so many and sets a clear direction for coordinated action by governments to more effectively address this critical issue. The Council of Australian Governments agreed that suicide prevention is a national priority at its 9 August 2019 meeting.

As an action of the Fifth Plan, all governments committed to drafting this strategy, the *National suicide prevention strategy for Australia's health system: 2020–2023* (the strategy). This three-year, whole-of-population strategy is part of the journey towards zero suicides in Australia. It is the first national suicide prevention strategy in Australia endorsed by every Commonwealth and state and territory Health and Mental Health Minister. Its focus is all suicidal behaviour (ideation, attempts and suicide).²

The strategy provides an anchor point for Commonwealth, state and territory suicide prevention strategies and for regional and local suicide prevention efforts. Its development has achieved consensus across all governments regarding how to strengthen system design and infrastructure, as well as strategic directions, priorities for change and roles and responsibilities.

The strategy brings into alignment the many individual suicide prevention actions that are already occurring in each jurisdiction into a consolidated, nationally endorsed strategy. The strategy acknowledges the lead role of the Commonwealth in determining national suicide prevention initiatives and notes the importance of jurisdictional flexibility during the implementation of national and regional priorities, which are necessarily dependent on budget cycles.








The strategy reaffirms all governments' commitment to implement systems-based approaches to suicide prevention, where multiple interventions are integrated and delivered simultaneously across a geographic region and/or to a priority population over long periods. It also reaffirms commitments to a whole-of-government approach to suicide prevention, where accountability for reducing suicide rates is shared across multiple portfolios and the three tiers of government.


The strategy provides strategic direction for suicide prevention efforts around Australia by setting out 24 areas of focus across four 'priority domains' and three 'priority foundations'. There is consensus from all governments and the suicide prevention sector more broadly that these areas of focus are the highest priority. The areas of focus have been chosen in the context of existing investments in suicide prevention, the opportunities and challenges facing suicide prevention in Australia and the maturity of our current system at the time of drafting the strategy. Figure 1 sets out the 24 areas of focus.

1 Note that in 2019 the Victorian Registry of Births, Deaths and Marriages implemented a new registration system. The implementation of this new system has resulted in some delays in processing death registrations (ABS 2019a). This has affected the Victorian and national suicide figures for 2018.

2 While some instances of self-harm are characterised by suicidal thinking, self-harm is often not an attempt at suicide; in some instances, people engage in self-harm rather than ending their life (Klonsky, 2007). Given this complexity, self-harm is not a focus of this strategy.

Figure 1: National areas of focus, for jurisdictional implementation

Priority domains	Priority foundations
 <p>Supporting individuals and communities to seek help and support others</p> <ul style="list-style-type: none"> • Endorse well-evaluated population-wide and localised context-specific suicide prevention public education campaigns • Where appropriate, support evidence-informed suicide prevention community connector training to better support individuals and communities • Support workplaces across Australia to become mentally healthy workplaces 	 <p>Building and supporting a competent, compassionate workforce</p> <ul style="list-style-type: none"> • Better target workforce development initiatives • Support suicide prevention competency throughout people's careers
 <p>Building a system of care to change the trajectory of people in suicidal distress</p> <ul style="list-style-type: none"> • Support and enable improvements in access to quality mental health services • Consider the design and integration of government-funded crisis helplines • Consider extending existing aftercare services for people who have attempted suicide to include anyone in suicidal distress • Consider establishing evidence-informed non-clinical alternatives to emergency departments • Consider new models of care in emergency departments that improve the experience for people with suicidal behaviour • Explore the effectiveness and best utilisation of digital technology for suicide prevention • Support evidence-informed systems to prevent the suicides of people receiving treatment in a public health service 	 <p>Better use of data, information and evidence</p> <ul style="list-style-type: none"> • Support suicide prevention research • Develop a new national system for collecting and coordinating information on suicide and self-harm • When a death occurs, maximise opportunities to use this data to ensure we learn from it • Harness data to better understand suicidal behaviours and target investments
 <p>Enabling recovery through post-crisis aftercare and postvention</p> <ul style="list-style-type: none"> • Increase the availability of aftercare programs following a suicide attempt • Recognise the importance of postvention bereavement services in supporting individuals and families to recover 	 <p>Government leadership that drives structures and partnerships to deliver better outcomes</p> <ul style="list-style-type: none"> • Support national best practice guidelines for suicide prevention • Consider the structures needed to strengthen Australia's suicide prevention approach • Consider the benefits of a single suicide prevention digital gateway
 <p>Community-driven Aboriginal and Torres Strait Islander suicide prevention</p> <ul style="list-style-type: none"> • Support a new national Aboriginal and Torres Strait Islander suicide prevention strategy and implementation plan • Support culturally safe post-suicide attempt aftercare models • Support clinically and culturally appropriate risk assessment tools and resources to support the assessment of risk of suicide in Aboriginal and Torres Strait Islander people 	



In the context of work already underway, these areas of focus both address existing gaps and commission work that enhances Australia's suicide prevention system in line with best practice. They are a combination of areas that will re-design and strengthen existing parts of the system, as well as seed new approaches and establish new infrastructure.

The areas of focus also support the diverse suicide prevention workforce to provide compassionate, evidence-informed care, build a stronger evaluation culture, coordinate investments in research and improve our understanding of innovation overseas and its potential translation to Australia. Improving the availability, quality and use of data to advance our knowledge of suicidal behaviour, identify and respond quickly to elevated rates of suicidal behaviour and track outcomes is also a focus of the strategy. To increase coordination and provide clarity to roles and responsibilities, the strategy proposes structures to bring people together to collaboratively plan, share and learn.

The strategy seeks to democratise suicide prevention by prompting a strong acceptance that suicide should no longer be seen as the preserve of specialist mental health services. Compassionate support and care must be tailored to the person's circumstances, needs and underlying causes of their distress. For some people, this will be mental health treatment, but for others, relationship counselling, alcohol and other drug use counselling or housing or employment support could be what is needed most. This involves new ways of conceptualising the suicide prevention 'system' and 'workforce'.

The strategy values people with lived experience of suicidal behaviour and the role they can have in providing insights into priorities for change, reducing stigma and discrimination by sharing their stories, meaningfully contributing to the design of interventions and offering compassionate support to people in suicidal distress through embedding peer workers in service delivery.

It also recognises that approaches are also more effective when they are community-driven and led, so that the differing priorities and the social, cultural, socioeconomic and spiritual needs of communities are reflected. Suicide prevention in Aboriginal and Torres Strait Islander communities needs to be undertaken in partnership with Elders and communities to strengthen the connection with culture, country and self-determination.

The strategy will also further existing whole-of-government efforts, which will be fully realised in Australia's next national suicide prevention strategy, proposed to be endorsed by the Prime Minister, Premiers and Chief Ministers in 2024.

Although the 24 areas of focus will strengthen the system in different ways and their contribution will vary, they need to be delivered in tandem to achieve the best outcomes. Echoing a systems-based approach, it will be their collective impact that will make the most difference.

The Commonwealth and each state and territory will progress the 24 areas of focus through implementing national, regional and local suicide prevention frameworks and priorities. The pace and sequence of implementation will necessarily vary across Australia to accommodate differences in priorities, approaches, systems and community needs. It is also dependent on the budget capacity in each jurisdiction over the life of the strategy. For some of the areas of focus, implementation had already begun alongside the strategy being drafted.

The collaborative nature in which the strategy was developed will continue as the areas of focus are progressed. A coordinated effort across governments, with lessons learnt openly shared along the way, will be important to improving suicide prevention outcomes in Australia.



Introduction

“ Loss after loss makes it feel like continual grief. It almost becomes expected. When someone in my community dies, my first thoughts often include: ‘Was it suicide?’ Heart attack, cancer or a car accident always seems like the least likely cause of death. I don’t want that to be normal anymore. I don’t want that to be normal for the kids growing up now. ”

26-year-old transgender person who has lost multiple friends to suicide

Tragically, 3,046 Australians lost their lives to suicide in 2018 (Australian Bureau of Statistics (ABS) 2019a). This equates to nearly eight Australians every day. Suicide is now the leading cause of death for Australians aged 15–44 years and the second leading cause of death for Australians aged 45–54 (ABS 2019a).

On average, a person who died by suicide in 2018 lost 36.7 years from their life (ABS 2019a). There were 105,730 years of life lost to suicide in 2018 (ABS 2019a). Approximately 75 per cent of people who die by suicide are male (ABS 2019a).

Each suicide affects a large circle of people. Research undertaken in 2018 indicates that for every person who takes their own life, more than 135 people experience intense grief or are otherwise affected (Ceral et al. 2018). On this basis, up to 411,210 Australians were affected by the suicide of someone close to them in 2018 alone.


People who are bereaved by suicide are also two to five times more likely to die by suicide themselves and are at risk of ongoing mental health concerns (SANE 2010). Children of a parent who suicides are three times as likely to take their own lives (Willcox et al. 2010).

Suicide also carries a heavy economic burden. KPMG has estimated that in 2016 suicide cost the Australian economy more than \$1.6 billion in lost earnings over the life course (Mental Health Australia and KPMG 2018).

Suicide attempts also have a devastating impact. The World Health Organization (WHO) suggests that for every adult who died by suicide, there may have been more than 20 others attempting suicide (WHO 2014). An estimated 65,000 Australians make a suicide attempt every year, translating to more than 180 people every day (Slade et al. 2009).

The impacts of suicidal behaviour (ideation, suicide attempts and suicide) are immediate, far-reaching and long-lasting. Research undertaken in 2016 with 3,220 Australians found that 85 per cent of respondents knew someone who had died by suicide, 89 per cent knew someone that had attempted suicide and 80 per cent had been exposed to both suicide and a suicide attempt (Maple et al. 2016). For Aboriginal and Torres Strait Islander people, this exposure can be more than twice that of non-Indigenous Australians (Maple et al. 2016).

In recent years, all Australian governments have made record investments in suicide prevention and the former Council of Australian Governments Health Council has agreed that suicide prevention is a national priority. However, with more than 3,000 Australians losing their life to suicide in 2018 (ABS 2019a), the infrastructure, systems and coordinated action that is required to effectively prevent suicide needs to be strengthened and, in some cases, put in place, and then sustained.



Suicide prevention approaches in other countries, where significant reductions in suicide rates have been achieved, provide evidence-informed³ insights into where the greatest opportunities are in Australia to strengthen our efforts. At the national, regional and local levels, these opportunities include:

- addressing the 'upstream' causal factors that create the trauma, disadvantage and distress that can promote suicidal thinking such as poverty, violence, bullying, abuse, isolation, racism, homophobia, transphobia, discrimination and stigma
- increasing the effectiveness and reach of prevention activities that build positive wellbeing and resilience in individuals and communities to guard against suicide
- strengthening public education about the warning signs for suicide and building confidence to talk about suicide, seek help and help others
- removing the stigma and discrimination that is still associated with suicide
- recognising that the harm from uncompassionate and unhelpful responses can exacerbate suicidal thinking and deter people from future help seeking
- ensuring that people who seek support when in suicidal distress experience a rapid, high-quality response that is effective, compassionate and available in a range of settings
- providing effective treatment and follow-up care after the immediate crisis that supports the person to reconnect with their reasons for living
- strengthening support to family members, carers and friends so they can better support their loved ones at risk and aid their recovery in times of crisis
- better supporting people and communities bereaved by suicide to recover
- establishing and strengthening national, regional and local suicide prevention infrastructure, such as data and information systems and an outcomes framework to support evaluation and monitoring, which will enable us to better understand suicidal

behaviour, respond more rapidly and track outcomes to maximise investments

- stronger coordination of suicide prevention efforts, with clearer roles and responsibilities between funders, and structures in place to enable joint planning, co-investment and information sharing.

This strategy comes at a time when some of these opportunities are already starting to be addressed.

It also comes at a time of unprecedented levels of suicide prevention activity across Australia. Numerous large-scale pilots are underway, interventions and approaches are being progressively scaled and there are many examples of innovation. Several of the national interventions are due to be brought to scale and seminal evaluations completed as this strategy is being implemented. These evaluations will be invaluable in shaping future investment decisions and will contribute significantly to the international evidence base.

During the drafting of the strategy, several other processes at the national level to further suicide prevention efforts commenced and, for some processes, were partly delivered. This includes the Productivity Commission's Inquiry into the Social and Economic Benefits of Improving Mental Health, the appointment by the Prime Minister of Australia's first National Suicide Prevention Adviser and a process led by the former COAG Health Council to determine whole-of-government suicide prevention priorities. In some states and territories, significant mental health reform processes were also initiated, such as the Royal Commission into Victoria's Mental Health System. Collaboration across these processes was a common goal, with the strategy a valuable input into the considerations and directions of each of these processes. Implementation of the areas of focus in the strategy will consider the outcomes of these processes, which are scheduled to be finalised after the strategy's publication.

3 In this national strategy, the term 'evidence-informed' has been purposefully used to reinforce a preferred approach to valuing and using evidence from many sources including: (i) evidence-based programs that have been experimentally evaluated (including overseas) and deemed efficacious in meeting specified goals; (ii) the implementation science of what helps or hinders the uptake, effective implementation and sustainability of proven programs, practices and policies; (iii) the qualitative insights of people with lived experience of suicidal behaviour; and (iv) traditional forms of knowledge and insight, such as from Aboriginal and Torres Strait Islander people.

The right support and systems can prevent suicide

Our knowledge about the effectiveness of suicide prevention interventions has grown, and is still rapidly growing. Investments in evidence-informed policies, interventions and systems can, and are, preventing suicide and supporting people in suicidal distress.

We know that many people who think about taking their own life are ambivalent but can't see any other way out of their situation. If the right help is provided, it is likely to result in a pathway to recovery. Stories from people with a lived experience who received the right help provide insights into how and when to intervene, and where the system is working well. The negative experiences are equally important to listen to and point to where change is most needed.

Suicide prevention is an issue that requires coordinated, combined and sustained efforts nationally, regionally and locally across a range of systems and settings, and from all levels of government. The international

evidence base supports focusing on a constellation of risk and protective factors by combining evidence-informed interventions at the individual and population levels into a multilevel and multifactorial approach sustained over long periods (WHO 2014; Zalsman et al. 2016).

The Fifth Plan, consistent with *WHO's Preventing suicide: a global imperative*, commits all governments to a systems-based approach to suicide prevention that focuses on the simultaneous implementation of the following 11 elements: surveillance; means restriction; media; access to services; training and education; treatment; crisis intervention; postvention; awareness; stigma reduction; and oversight and coordination (WHO 2014).


These elements or interventions target the whole population (universal interventions), people with elevated risk (selective interventions) and people in immediate need of help (indicated interventions) – see Table 1.

Table 1: Universal, selective and indicated evidence-informed interventions

Intervention type	Target group	Evidence-informed examples
Universal	Whole of population	Addressing risk factors for suicide such as childhood trauma, loneliness and isolation
		Restricting access to means
		Community connector training
Selective	Vulnerable individuals or groups at greater risk of suicidal behaviour	Localised public education campaigns targeted to high-risk groups
		Postvention bereavement services
		Programs for high-risk occupations
Indicated	Individuals experiencing suicidal behaviour	Crisis phone helplines and online support
		Evidence-informed assessment, treatment and ongoing management of suicidal behaviours
		Follow-up support post a suicide attempt

Source: Adapted from WHO 2014.

Note that the term 'gatekeeper training' has been replaced with 'community connector training' – see footnote 7.



In a systems-based approach, interventions are integrated and delivered simultaneously across a geographic region and/or to a priority population over long periods. The synergistic effort of multiple interventions is thought to produce outcomes greater than the sum of the individual parts (Van der Feltz-Cornelis et al. 2011). As the individual interventions vary in their evidence base and effectiveness, simultaneous, sustained implementation is key to improving outcomes.

Most governments in Australia have funded systems-based approaches to suicide prevention that are informed by the Black Dog Institute's LifeSpan model in which nine evidence-informed strategies from the population level to the individual are implemented simultaneously within a localised region (Black Dog Institute 2017).

Two other systems-based approaches operate in some areas of Australia. The European Alliance Against Depression is a regional program of interventions that simultaneously targets depression and suicidal behaviors and is based on the model region of Nuremberg Alliance Against Depression, which reduced suicidal acts by approximately 20 per cent in two years (Hegerl et al. 2006). The Zero Suicide Framework model is being implemented in some healthcare settings and is based on the belief that suicide deaths for individuals under the care of health and behavioural health systems are preventable (Labouliere et al. 2018).

For Aboriginal and Torres Strait Islander people, a systems-based approach is also recommended, with the interventions, cultural considerations and success factors required articulated in the 2015 Commonwealth-funded Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project (ATSISPEP).

Researchers have estimated that by using a systems-based approach, over time it may be possible to prevent up to 20 per cent of suicide deaths and up to 30 per cent of suicide attempts (Krysinska et al. 2016). Robust, publicly available evaluations of these four systems-based approaches in Australia are essential for advancing our knowledge about the implementation science of a systems-based approach and the level of change achievable. Evaluations of the four LifeSpan high-fidelity research sites, the Victorian Government's 12 place-based trials (see Best practice spotlight on the following page) and the Commonwealth's National Suicide Prevention Trial Sites, which all adopt a systems-based approach, are due to be released in 2020 and 2021.⁴

Suicide prevention is also more effective when integrated with broader, cross-sectoral responses that address the social and cultural determinants of poor health and wellbeing, including childhood trauma, family violence, unemployment, poverty, displacement, experiences of discrimination, lack of education opportunities, isolation, loneliness and alcohol and other drug misuse.

Under a systems-based approach each intervention needs to be co-designed and co-produced by people with lived experience of suicidal behaviour and draw on implementation science, data and analytics. Interventions are part of integrated pathways in multiple systems and delivered by highly capable, compassionate workforces, including those with a lived experience of suicidal behaviour.

Figure 2 captures Australia's systems-based approach to suicide prevention.

⁴ Note that some of these sites are also conducting local evaluations, which will also be useful for building the evidence base. Across all sites, evaluations vary in their focus, depth and timing.

Best practice spotlight

Place-based approaches to suicide prevention in Victoria

The Victorian Government and Victorian Primary Health Networks (PHNs) have partnered to implement coordinated place-based approaches to suicide prevention. The 12 place-based trials aim to reduce rates of suicide and suicide attempts, strengthen individual resilience, improve wellbeing and deliver broader system improvements.

In each location, a local suicide prevention group is supported by a coordinator to develop a local community action plan. The activities in each action plan are guided by the evidence and include supporting people with lived experience to talk about suicidal behaviour and to train the community to recognise and respond to people at risk of suicide.

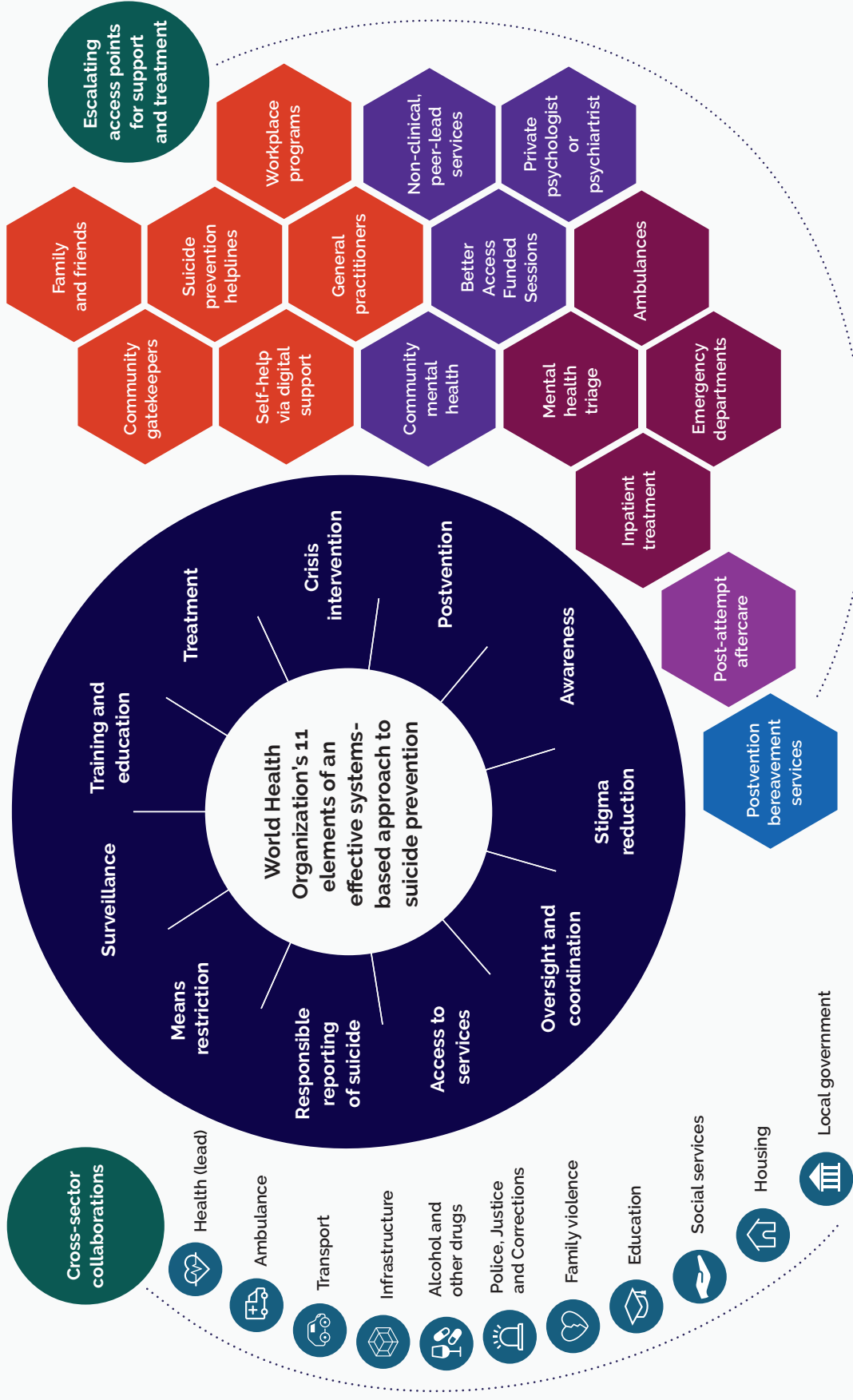
They bring together different parts of the community, including people with lived experience of suicidal behaviour, community agencies, the Aboriginal community-controlled sector, schools, businesses, local councils, transport, police, health services, ambulance services and others to identify what is needed to prevent suicide and to find solutions that will work for the local community. This is a new way of working together to prevent suicide that requires strong collaboration across many sectors.

‘ One of the things that’s definitely changed is the recognition from stakeholder groups that by themselves they can’t make the difference – so it means they’re more willing to work collaboratively ... the most significant highlight for me is actually seeing the epiphany from some key people in the community specifically around, ‘Okay, I wanna be part of this,’ rather than, ‘What can I get out of it?’ ... it actually meant that we had some resisters move from resistance to ‘I’m all in’. ’

Participant in the evaluation of Victoria’s place-based trials⁵

5 Unpublished evaluation outcomes, Victorian Department of Health and Human Services, June 2019.

Figure 2: Australia's systems-based approach to suicide prevention



Principles

- ▶ Everyone has a role to play in suicide prevention
- ▶ Community wellbeing and resilience are fundamental
- ▶ Evidence-based, integrated cross-sectoral approaches are needed
- ▶ Quality interventions are available across the lifespan
- ▶ Earlier intervention to avoid crisis
- ▶ Support and care is matched to individual needs and preferences
- ▶ Care is culturally appropriate and compassionate
- ▶ Approaches are tailored to local circumstances and priorities
- ▶ Communities are empowered to lead local efforts
- ▶ People, families and communities are supported to recover
- ▶ Lived experience is valued

Enablers

- ▶ Data and information
- ▶ Research and evaluation
- ▶ Digital solutions
- ▶ Workforce
- ▶ Government leadership and coordination
- ▶ Information sharing and translation into practice
- ▶ Lived experience
- ▶ Commonwealth
- ▶ States and territories
- ▶ Non-government organisations/philanthropic
- ▶ PHNs

Jess' story

I have diagnoses of bipolar disorder, generalised anxiety disorder, complex post-traumatic stress disorder and obsessive compulsive disorder. Long list, I know. When I tell people I have attempted suicide they often assume it is because one or more of these disorders got the better of me. That it all became too much.

What you might be shocked to know is that my suicide attempt was more simple in its origin. It had more to do with how the world responded to me as a mentally ill person than the mental illnesses themselves.

The thing is, when I was suicidal due to mental illness, I could debate with myself and reason that this was in my head and that it would pass. I would think to myself: *Your bipolar is making you suicidal, you just need to wait it out.* But when my life circumstances just kept getting worse, I couldn't see that it would pass. I felt stuck and unable to move. Like I was sinking into the earth.

I was unemployed, and as a young mentally ill person I thought no one would ever want to hire me. I was overwhelmed by the pressure that my honours degree was placing on me. I felt unable to balance life's demands. I didn't think I would ever be a functioning adult. My particular traumas (sexual abuse, domestic violence and bullying) made me feel like a burden to others.

It wasn't that life was too much; I was too much. I felt abandoned by society. Like I did not belong. Even amongst friends I felt like no one saw me or would miss me if I was gone.

Treating my suicidal thoughts like symptoms of mental illness removed them from the reality that they were caused by a lack of community – both community engagement on my part and community support by the way of others.

There were two things that pushed me over the edge the night of my suicide attempt: (1) I didn't get a job I really wanted, which further increased my feelings of isolation and lack of connection to my community; and (2) when I shared this news with people I wanted to connect to, they responded apathetically and with condescension.

I felt removed from my community. No one wanted to take responsibility for the suicidal young person in their flock. I was left to fend for myself. A lot of media campaigns emphasise how if you are struggling with suicidal thoughts, you should ask for help. But people honestly don't understand how hard it is to ask for help in a world where you don't feel welcomed.

I'm not going to say my life is all rainbows and smiles now. I still struggle with suicidal thoughts almost every day. But they are easier to deal with now because I am more connected to my community. I am working in mental health advocacy and research. I have re-engaged with hobbies. I have completed my studies (for now). And most of all, I have been able to build a sense of safety around my mental health with the help of my community.

Recovery is a complex concept. And it is not necessarily one that I identify with. To me, recovery implies that there was something wrong with me before. Which there wasn't. My symptoms and suicide attempt were all a sane reaction to insane circumstances. I prefer to think of myself as managing my symptoms now.

I manage my symptoms and suicidality with regular therapy, medications and an extra dose of love and support. I have learned that there is nothing wrong with asking people to love you a little bit harder on some days. I no longer try to tough it out. I put safeguards in place so that when I am suicidal I am less likely to act on it. I do this because if there is one thing I learned from my attempt it is that I know I want to be alive.

Jess, 24, Victoria



Whole-of-government suicide prevention

An underlying principle in a systems-based approach to suicide prevention is whole-of-government efforts that recognise that suicide prevention should occur across the life course and in the multiple settings where people live, work and play. Suicide is a whole-of-society issue, and a whole-of-government approach is needed to achieve real change.

In a whole-of-government approach, accountability for working towards zero suicides is shared across multiple portfolios. Although suicide prevention needs to be led by the health portfolio, other social policy portfolios such as justice, education, social services and Indigenous Affairs must all embed suicide prevention into their systems. Other systems such as transport, planning, sport, environment and industry all have important contributions to make. A whole-of-government approach also includes all three levels of government – Commonwealth, state/territory and local government.

An important first step in a whole-of-government approach is to strengthen the health system's response to suicide prevention. People in suicidal distress often first present to our health systems, and it is important that their call for help is answered effectively and compassionately. The health system focus of this strategy will advance this – through its 24 areas of focus and the commitments Health and Mental Health Ministers have made to better define roles and responsibilities and to jointly plan and fund suicide prevention activities.

This strategy also commits Health and Mental Health Ministers to engaging their ministerial colleagues about shared accountability for suicide prevention. It signals that Australia's next national suicide prevention strategy, to be released in 2024, will be a whole-of-government strategy encompassing all relevant portfolios and endorsed by First Ministers.

At the Commonwealth and state and territory levels, there are already examples of effective whole-of-government suicide prevention approaches and interventions, and this continues to increase as collaborations mature. The work of the National Suicide Prevention Adviser also has a focus on strengthening whole-of-government efforts. This work over 2019 and 2020 will provide valuable directions to national, regional and local government efforts and will be a call to action to move suicide prevention efforts in Australia from largely a health responsibility to a responsibility that is shared across many portfolios.

The available evidence points to interventions in each portfolio where investments should be prioritised. Many of these interventions are already being piloted or implemented in Australia (see Table 2).



Table 2: Universal, selective and indicated evidence-informed interventions⁶

Justice	Education	Human/social services	Transport, infrastructure, building and planning
<p>Strengthening and expanding joint police, ambulance and mental health frontline responses to mental health crises in the community</p> <p>Police automatically notifying postvention bereavement service providers of a suicide as part of a coordinated interagency postvention response</p>	<p>Supporting early learning services and schools to become <i>Be You</i> Learning Communities and implement the <i>Be You</i> whole-learning community approach to mental health and suicide prevention</p> <p>Promoting access to free face-to-face and telephone counselling for students with mild to moderate mental health issues (on site via school-based mental health professions or off site via partnerships with mental health providers)</p> <p>Building the capacity of school communities to recognise the warning signs for suicide through gatekeeper training for teachers, assistant principals, principals, school-based mental health professionals and parents</p>	<p>Building the capacity of family and domestic violence workers to recognise and de-escalate a suicidal crisis and refer people with suicidal behaviours for appropriate follow-up (this should include building stronger links between family violence and suicide prevention services)</p> <p>Supporting children in out-of-home care who may be at risk of suicide through past experiences of trauma and abuse via ongoing risk assessments, access to appropriate counselling and treatment, monitoring of mental health and wellbeing and safety planning</p>	<p>Putting systems in place for suicide hotspot identification and monitoring and implementing preventative measures at each hotspot in partnership with local government (this should include promoting crisis support helplines and other avenues for help)</p> <p>Reviewing and strengthening safeguards in building legislation, regulations and codes to reduce means to suicide for both public and private infrastructure (existing and new)</p>
WorkSafe/OHS	Local government	Indigenous affairs	All portfolios
<p>Supporting workplaces to use e-mental health and suicide prevention strategies and resources to support staff, including online suicide prevention training and self-help resources</p> <p>Funding evidence-informed workplace suicide prevention training for managers, prioritising industries with elevated risks of suicide such as military, trades, mining, veterinarians and agricultural workers</p>	<p>Including suicide prevention in municipal public health and wellbeing planning</p> <p>Encouraging local councils to initiate and lead inclusive, community-wide suicide prevention networks</p>	<p>Strengthening the capacity of departments in this portfolio to address the social determinants of health that can improve social and emotional wellbeing for Aboriginal and Torres Strait Islander people and reduce the risk of suicide</p>	<p>For departments and agencies that employ frontline staff, developing and implementing mental health and wellbeing plans as part of their comprehensive occupational health and safety framework</p>

⁶ Note that the delivery of many of these interventions involves multiple portfolios and shared responsibilities. The table above denotes the lead portfolio.

About this strategy

This strategy supports and furthers the existing efforts of governments, non-government organisations, PHNs, the private sector, research institutes and people with lived experience of suicidal behaviour. Its publication completes Action 4 of the Fifth Plan. It is consistent with the suicide prevention strategies and frameworks of the Commonwealth and state and territory governments (refer to Appendix 1).

All governments are also making investments in other portfolios that support suicide prevention. This includes programs and services to reduce the harm from family violence, alcohol and other drugs and discrimination and racism and programs designed to build social cohesion, increase education and employment and support Aboriginal and Torres Strait Islander peoples' social and emotional wellbeing.

Complementing the efforts of governments, non-government organisations also provide valuable leadership and research and deliver services and programs. The private sector helps many Australians prevent, better manage and recover from suicidal behaviour.

Vision

Australia's journey towards zero suicides is achieved through a suicide prevention system where evidence-informed strategies, programs and services are coordinated across all sectors to:

- promote resilient, mentally strong individuals and communities
- support people at risk
- effectively and compassionately care for people experiencing or affected by suicidal behaviour.

How this strategy was developed

The National Suicide Prevention Project Reference Group, a working group of the Mental Health Principal Committee, guided the strategy's development (see membership at Appendix 2). Valuable advice from a wide range of organisations and people, including people with lived experience of suicidal behaviour, was provided through an open consultation process in April 2019. Experts in New Zealand, Scotland and Ireland also contributed to the drafting.

Progressing the areas of focus

The Commonwealth and each state and territory will consider opportunities to progress the 24 areas of focus in line with national, regional and local suicide prevention frameworks and priorities. The pace and sequence of implementation will necessarily differ across Australia to accommodate differences in priorities, approaches, systems and community needs. It is also dependent on the budget capacity in each jurisdiction over the life of the strategy. For some of the areas of focus, implementation had already begun alongside the strategy being drafted.



Expected impact over time

Comprehensive suicide prevention plans in other countries such as Scotland have successfully reduced suicide rates over 10 or more years (Scottish Government 2018).

It is hoped that by governments, as able and within budget capacity, continuing to give priority to the 24 areas of focus in this strategy, in the future Australia will be able to tell a similar positive story. Although we all want to see suicide rates go down quickly, the evidence indicates that suicide prevention efforts take time to have an impact at the population level.

An important element of maturing Australia's suicide prevention system is robust outcomes monitoring. This must be enabled through developing an Australia-wide outcomes framework for suicide prevention. This includes identifying intermediate outcomes on the causal pathway between inputs (interventions) and final outcomes (suicide rates) and being able to link individual interventions to intermediate outcomes to better identify the interventions with the most impact. This outcomes framework will be developed as part of Australia's next suicide prevention strategy.

Why was it important to develop this strategy with people with lived experience of suicidal behaviour?

People with lived experience of suicidal behaviour have a valuable and unique role in suicide prevention. This includes people who have experienced ideation, suicide attempts and/or have been bereaved by suicide.

Lived experience helps change the culture surrounding suicide by creating deeper understanding and empathy and encouraging action that meets the needs of people. People who have experienced suicidal behaviour and have used services are best placed to identify existing gaps and provide advice on how their needs may be met in an effective and compassionate way.

“ Those who have lived through a suicidal crisis and attempts have taught us what people need when in crisis, what support can represent the difference between life and death. We know the type of knowledge and support people need to equip them to better save their loved ones and, tragically, through far too much experience, we know what it is to lose loved ones and the support that can help those left behind, holding them together when everything is shattering around them. ”

*Bronwen Edwards, CEO and Founder,
Roses in the Ocean*

Priority domains

Supporting individuals and communities to seek help and to support others

“ It is the stigma attached to suicide that had, and continues to have, a negative effect on my family. The shame and lack of support was incredible. I discovered that stigma is still very much alive and well. When someone you love dies of illness or a sudden car accident, it is common in most cases that your family and the community you live in will rally around you. When a loved one suicides this same level of support is not given to those left behind. ”

41-year-old woman from regional New South Wales whose grandmother died by suicide

Why is this a priority?


An important element of a systems-based approach is providing opportunities and entry points to individuals and communities to help themselves and to support others to seek help for suicidal behaviour.

Many people who take their own life are not under the care of specialist mental health services, and around half have not had recent contact with their general practitioner (GP) (Owens et al. 2009). Family, friends and community members may be the only ones to know that a person is distressed. Their capability and confidence to recognise the depth of distress a person is experiencing and to compassionately and effectively respond can be lifesaving.

To increase suicide prevention literacy, governments have invested in public education campaigns. These campaigns focus on encouraging safe, open dialogue about mental health and wellbeing and increasing individuals' confidence to seek help and to help others. The scale and delivery modes of these campaigns mean they can reach large numbers of people across geographic boundaries. They also strengthen connections at the individual and community levels and empower organisations to support the positive mental health of their workforce or members.

Investments have also been made in evidence-informed suicide prevention community connector training.⁷ This training builds the capacity of individuals and communities to better recognise the warning signs of suicide and to intervene to increase the probability that a potentially suicidal person is identified, supported and, where necessary, referred for assessment and treatment (Orygen 2018; Yonemoto et al. 2019). The training builds local safety nets to guard against suicide, with thousands of community members across Australia now trained.

⁷ Community connector training is also referred to as 'gatekeeper training'. Note that the term 'community connector training' has been adopted as the preferred term in this national strategy. This is to avoid confusion with the important role that GPs have as 'gatekeepers' in our health system. Note that the term 'community connector' is not meant to be associated with any particular program or brand.



Establishing suicide prevention networks across Australia has also been supported. These bring local communities together and support them to raise awareness, increase compassionate conversations and break down stigma and discrimination associated with suicide. Communities are an important focus because they know their history, culture, connection points/places, services and vulnerable members.

It is important to eliminate the stigma and discrimination around suicide that is still present in our society. Stigma and discrimination may lead to feelings of shame, helplessness, fear, worthlessness and self-doubt. It can discourage people from disclosing suicidal behaviour, decrease the likelihood of seeking support and create additional distress.

Using data, information and personal stories, and supporting individuals and communities to have open, meaningful conversations, can reduce stigma and discrimination. More broadly, the range of programs governments fund to reduce the stigma and discrimination associated with mental ill health (especially severe mental illness) will also positively impact on help seeking for suicidal behaviour where there is an intersection. This includes the stigma and discrimination actions in the Fifth Plan.

What are the areas of focus?


1: Endorse well-evaluated population-wide and localised context-specific suicide prevention public education campaigns

“ Everyday Australians want to help people they care about; however, they do not always have the confidence or skills to do so and there is a fear of getting it wrong or making it worse. People with a history of suicide attempts and suicidal thinking confirm that empathetic, non-professional support is helpful. ”

*Melbourne University Research 2017
to inform the #YouCanTalk campaign*

Analysis of deaths by suicide in Queensland from 2013 to 2015 found that 55 per cent of people had communicated their intent or had attempted suicide previously, with 43 per cent doing so in the preceding year (Leske 2019). Evidence indicates that many people who die by suicide communicate their suicidal thoughts and intentions to family members and friends (Owens et al. 2009).

Unfortunately, families and friends report being uncertain about how best to interpret and respond to a loved one at risk (Owens et al. 2011). A 2019 survey of 1,026 Australians for R U OK? found that 41 per cent didn't ask R U OK? in the preceding 12 months because they were not sure that they knew the signs, in contrast with 51 per cent indicating they wished that someone had asked them if they were okay (Colmar Brunton 2017).



Public education campaigns that raise awareness of the warning signs for suicide and prompt helpful responses have significant benefits for both those at risk and those wanting to offer support. Through understanding warning signs, it is possible to identify a person entering into a suicidal crisis and respond effectively to address immediate safety concerns and orientate them towards help. Public education campaigns also play an important role in positively changing social norms around suicide, including ignorance, fear and uncertainty.


The effectiveness of large-scale public education campaigns is strengthened when coupled with localised, context-specific campaigns that focus on places, communities and populations at greater risk such as Aboriginal and Torres Strait Islander people, lesbian, gay, bisexual, transgender/transsexual, intersex and queer/questioning (LGBTIQ+) communities, youth, older people, men and some culturally diverse communities. Nuanced messages guided by local data and priorities ensure these campaigns resonate and promote positive change. Many of these campaigns are developed by or in partnership with these communities. Adherence with Australia's *National Communications Charter: A unified approach to mental health and suicide prevention* is important.

Governments have funded suicide prevention public education campaigns at the national, state/territory and local levels. The Commonwealth has funded R U OK?, Everymind, Reach Out Australia and #chatsafe for national campaigns to reduce stigma, encourage conversations and provide vital support and resources to individuals and communities at risk. National campaigns reinforce campaigns at the state/territory or local level.

These campaigns are funded in the context of a systems-based approach to suicide prevention, where they are part of a multi-intervention response. This is important because campaigns are more effective when delivered this way, rather than using a standalone approach (Torok et al. 2017). Local services must also be engaged in the campaigns so they can support those seeking help.

The #YouCanTalk campaign, delivered by 10 mental health organisations, has also successfully prompted conversations about suicide by providing crucial evidence that talking about suicidal thoughts and behaviours is helpful, not dangerous. Contrary to commonly held beliefs, research underpinning this campaign found that acknowledging and talking about a person's suicidal thoughts reduces, rather than increases, suicidal ideation and can lead to improvements in mental health (Nicholas et al. 2017).

This research also found that almost 50 per cent of respondents believed that helping a person at risk of suicide requires the skill of a professional; about 40 per cent believed that suicide happens without warning; and about 30 per cent of respondents believed that asking someone about suicide could make them start thinking about it or trying to help someone at risk could make the situation worse (Nicholas et al. 2017). These incorrect beliefs have the potential to inhibit helpful behaviours. It is important that public education campaigns address these beliefs to change them.



2: Where appropriate, support evidence-informed suicide prevention community connector training to better support individuals and communities

‘ I believe the suicide of my best friend could have been prevented if those that were close to him were alert to the signs. I think it would be great to raise awareness about the symptoms of depression and what to watch out for when it comes to depression and suicide. Also, he belonged to a high-risk demographic for suicide – he was a teenage male around the age of 20 at the time. I believe the cause of his suicide was due to social anxiety and pressure, as he was facing challenges and having many issues with his friends before his suicide (he probably felt very isolated and alone). He did not suffer any financial problems, health issues, and was smart, funny, and popular. He also had a loving family. ’

23-year-old woman from New South Wales whose best friend died by suicide

The United Nations and WHO have recommended community connector training as one of the most promising strategies for preventing suicide when combined with other interventions in a systems-based approach (Kysinska et al. 2016; Mann et al. 2005). Although there is limited evidence that it leads to decreases in suicide attempts or deaths, evidence shows it does reduce stigma and discrimination towards people, raise awareness of suicide risk factors and improve suicide prevention skills and intention and motivation to support people in suicidal distress (Ghoncheh et al. 2016; Griesbach et al. 2008; Isaac et al. 2009).

Community connectors include frontline workers in health, safety and wellbeing roles, such as police, paramedics and firefighters, and people whose roles place them in a position to notice when someone may be at risk, such as pharmacists, alcohol and other drug workers, family violence workers, aged care workers, general practice receptionists, counsellors (relationship, financial and rural), teachers, sports coaches, youth workers and community elders and leaders. Once trained, community connectors form a local 'safety net' against suicide in their communities and workplaces.

A large number of community connector training programs are available across Australia, with wide heterogeneity in content, implementation, scale and evaluation approach (Hawgood et al. 2015). Although there are no statistics available on how many Australians have been trained, it is likely to be tens of thousands.⁸ More recently, online training is benefiting communities and professions who find it difficult to attend training during business hours and enables large reach at low cost. Increasingly, training is being delivered in partnership with people with lived experience of suicidal behaviour. It is also being adapted to better meet the needs of groups and individual communities, including through the consideration of culture and language.

⁸ For example, the Commonwealth-funded Wesley LifeForce Gatekeeper Suicide Prevention Training has trained more than 30,000 people since 1995 (Wesley Mission 2019).

Best practice spotlight

The Commonwealth, states, territories and PHNs all fund community connector training. There is significant variance in content, depth and the strength of evidence for each program, as well as the reach and the target group(s) for the training. Uncoordinated funding has led to poor targeting, inequitable access, variances in competencies and effectiveness and an inability to understand scale. The evidence base for community connector training would also benefit from an investment by governments in coordinated evaluations. Clear guidance is also needed for how often the training should be repeated to maintain competency, with useful precedents overseas.

Agreement should also be reached on the high-priority groups for community connector training and the recruitment strategy, content and delivery method tailored accordingly. Effective settings to reach these target groups should also be explored – for example, men's sheds to reach men, and schools and sporting clubs for parents and carers.

In Aboriginal and Torres Strait Islander communities, Elders and community leaders perform a valuable role in suicide prevention, often with little support. There is a need for specific Aboriginal and Torres Strait Islander training that builds the capacity of Elders and community leaders to intervene early with people who are at risk and to support them to seek help (Nasir et al. 2017).

Deadly Thinking, Suicide Story and Aboriginal Mental Health First Aid are examples of culturally safe community connector training designed by Aboriginal and Torres Strait Islander people for Aboriginal and Torres Strait Islander people. Many of these programs adopt a 'train the trainer' delivery method, empowering Elders and community members to deliver the programs in their own communities.

Community connector training to support the Big Gay Day event Collaboration, Brisbane North Primary Health Network

As part of the National Suicide Prevention Trial, Brisbane North PHN commissioned suicide intervention skills training for individuals, community connectors and professionals who work with LGBTIQ+ communities.

This began by consulting with key stakeholders and peak LGBTIQ+ organisations in the region to identify needs and gaps in knowledge. The consultation revealed that many professionals – including bar and club staff, hairdressers, beauty therapists and personal trainers – who regularly have contact with LGBTIQ+ people, had little or no experience in suicide intervention. This then led to community connector training being provided to bar staff and event volunteers in the lead up to the Big Gay Day, which is an annual day and night party at the Wickham Hotel in Brisbane.

One of the participants noted:

“ This training and others like it are important in everyday life. Given our community suffers higher rates of suicide, training to recognise and assist are important skills to have. Stigma and fear of the unknown cause complacency and lack of skills costs lives. I think having these skills is vital for anyone working with our LGBTIQ+ community. ”



3: Support workplaces across Australia to become mentally healthy workplaces

‘ **Men have to learn – I had to learn that it’s okay to admit that you’re having trouble and it’s okay to ask for help. That’s an attitude. An attitude stopped me from doing it earlier. A change in attitude helped me get there.** ’

Participant in the 2018 evaluation of the MATES in Construction workplace program

With the median age of deaths by suicide in Australia in 2017 being 44.5 years, most people who take their own lives are of working age, with some traditionally male-dominated occupational groups such as military, trades, mining and agricultural workers having disproportionately high rates of suicide (ABS 2019). Workplaces are an important setting for suicide prevention because they can actively promote positive mental health and wellbeing, as well as supporting staff to recover from mental ill health (Fossey & Harvey 2010).

A mentally healthy workplace is one where risk factors are acknowledged and appropriate action taken to minimise their potential negative impact on a person’s mental health. At the same time, protective or resilience factors are fostered and maximised (Harvey et al. 2014).

Creating mentally healthy workplaces for the 12.6 million working Australians has benefits for both employers and employees. Workplaces that supports individual mental health lead to reduced absenteeism, increased staff engagement and improved productivity (Harvey et al. 2014).

There are many examples of workplaces across Australia, of all sizes and in all industries, that are mentally healthy workplaces. Some have been supported by government funding or programs from the health and/or occupational, health and safety portfolios. For example, WorkSafe NSW has funded free mental health training to 3,600 managers in high-risk industries such as transport, postal/warehousing and manufacturing. In 2019–20 the Commonwealth provided \$11.5 million over four years for the National Mentally Healthy Workplace Initiative, which brings together business, unions, the mental health sector and regulators to promote mentally healthy workplaces across all states and territories.

MATES in Construction, Northern Territory

Suicide rates in the Northern Territory construction industry during the period 2013–2015 were 45/100,000 compared with a national average of 22/100,000 – more than twice the national average for construction workers (Milner & Maheen 2017). A 2015 report concluded that the annual cost of suicide and suicidal behaviour among the Northern Territory construction industry amounted to \$67.82 million (in 2012 health dollars) (Doran, Ling & Milner 2015). In response, MATES in Construction was expanded to the Northern Territory in 2018. In its first full year of implementation (2019), 266 site contacts were made, 490 workers were trained in General Awareness Training (GAT), 87 as Community Connectors and 11 as ASIST workers.

MATES in Construction is an integrated program of training and support. MATES uses training to raise awareness that there is a problem with suicide and its contributing risk factors in the construction industry and that everyone can be part of the solution. Support is then provided through clear pathways to help, case management processes ensure that workers in need of support are connected to appropriate help, and on-site visits by field officers support the site and its workers with an ongoing presence until the site closes. Other activities include case management, critical incident support, general awareness training, community connector training, a MATES support volunteer network and a 24/7 support line. When MATES in Construction was implemented in Queensland, within the first five years of operation there was an 8 per cent reduction in suicide rates among male construction workers (Martin et al. 2016).

“MATES is one of the most valuable assets the industry has for combatting stigma and the barriers around the topic of suicide and mental health. We feel safe to bring these skills that MATES has given us into work and we are showing to the community that we are proactive when it comes to helping a mate out and get them the help they need. Hutchinson Builders are proud to support the best industry evidence program and we will continue to support Matt and MATES in the NT.”

*Michael Jennings, Safety Advisor,
Hutchinson Builders, Darwin*

“Because construction workers, we're quite a funny group. We always stick together. But yeah, I never really heard of beyondblue, or Lifeline, or Salvos, or anything. I knew they'd been around, but I didn't know the actual support that they actually put together until I did the MATES in Construction, and I thought, what a great course, you know? They're actually looking after, like, a brotherhood, you know?”

*Participant in the 2018 evaluation of the
MATES in Construction workplace program*



Best practice spotlight

What positive change will making these areas of focus a priority achieve?

- More Australians will understand the warning signs for suicide, know how to start a positive conversation with someone who is struggling and be able to assist them to access help.
- More community members will be trained to have conversations with people at risk of or experiencing suicidal behaviours and support them to seek help.
- Suicide-related stigma and discrimination will be reduced.

Potential future priorities

- Consider a large-scale, multi-mode public education campaign(s), learning from the approaches taken in other countries (such as Scotland) where this has been successful.
- Support more workplaces across Australia to become mentally healthy workplaces.
- Increase the coverage of community connector training by using at-scale delivery methods.

Community connector training - Capital Health Network and ACT Health

Through the ACT Government's Lifespan Program, the Capital Health Network and ACT Health have invested in the Black Dog Institute's Question, Persuade, Refer (QPR), which is a suicide prevention training program that teaches lay and professional people to recognise and respond positively to someone exhibiting suicide warning signs and behaviours. The free QPR training is designed to detect persons who are in the thinking or ideational phase of a suicide plan. It may also enable natural helpers to identify people at risk who have already made one or more attempts.

While informative for mental health professionals, the course and content is specifically targeted at audiences with no assumed knowledge of mental health or suicide prevention, and aims to provide them with the skills to connect someone at risk with professional support.

QPR online is free in the ACT and takes approximately 60 mins to complete. It can be completed over multiple sessions. In addition, an individual who has finished QPR can continue to access the program for 3 years to refresh their skills and knowledge.

Building a system of care to change the trajectory of people in suicidal distress

6 Timely support when my husband is suffering intense suicide ideation. Going to the emergency department and having to wait 5 to 8 hours through the night before he gets to see a mental health professional is not an acceptable level of crisis support. I've never experienced greater difficulty, and these events were harmful and traumatising. ’

Rita, metropolitan Victoria, caring for her partner following a suicide attempt⁹

Why is this a priority?


Accessible, evidence-informed care options for people in suicidal distress are limited or missing from Australia's suicide prevention system. GPs and other clinicians consistently report having limited referral options and when a referral can be made, people with lived experience often report delays in accessing the service, out-of-pocket costs and, sometimes, poor experiences and outcomes. A key focus of this strategy is creating and strengthening the pathways to, and through, care for people in suicidal distress.

Recognising that suicidal behaviour can occur in the context of acute and chronic mental ill-health, the availability of high-quality treatment for mental health problems, including via digital technology, remains fundamental. Issues of equitable access, waiting times to see a clinician, especially when in crisis, and out-of-pocket costs in both the public and private sector are experienced right across Australia and affect some people and groups disproportionately. Demand for mental health services has increased significantly and is projected to continue to increase with population growth and the escalating complexity of mental health issues. Demand can also surge in times of natural disasters and economic downturn.

Many people in suicidal distress present to emergency departments across Australia. Although there will always be a need for emergency departments to provide timely, high-quality and compassionate assessment and care, feedback from people with lived experience of suicide is that emergency departments can sometimes cause further trauma. Unless urgent attention for a medical condition is needed, emergency departments are not best placed to care for a person in suicidal distress.

Parallel to improving the emergency department experience, there is a need to establish accessible non-clinical services that people in suicidal distress can use to feel safe and supported. There are opportunities to learn from models both overseas and within Australia that offer a better experience and outcomes. These include 'safe haven' cafés, safe spaces, in-reach peer support and long stay retreats.

9 Sourced from Coker et al. 2019



Crisis helplines are another important pathway to care, offering accessible, non-judgemental, anonymous support and referral and have the potential to perform a larger role than they do currently. GPs are also essential. Internationally up to 88 per cent of people who suicide have had contact with a primary care physician within a year of their death and up to one half within one month (Leavey et al. 2017). GPs need to be supported to have safe, compassionate conversations with people at risk, with local referral pathways available quickly and affordably so that the help seeking they encourage can be converted to action.

“ **Suicide has been treated with a medicalised model, a very clinical model and that’s not what people are needing or asking for in every instance. It’s not one or the other, because there are definitely cases where people need clinical intervention. But there are a lot who don’t and who need alternative ways to get care and support than those currently available. What’s exciting is that those alternatives are very much on the agenda.** ”


Bronwen Edwards, CEO and Founder of Roses in the Ocean

What are the areas of focus?

4: Support and enable improvements in access to quality mental health services

Mental illness is a significant risk factor for suicide. Research using coronial data in Victoria established that 52 per cent of the people who had taken their life from 2009 to 2013 had a documented diagnosis of a mental illness (Clapperton et al. 2018). Similar results were observed in Queensland, with research using the Queensland Suicide Register finding that of the 2,085 deaths reported between 2013 and 2015, 51 per cent of people had a mental health condition (Leske et al. 2019). This is further supported by 2019 ABS research that found that of the 3,127 people who took their life in 2017, 64.9 per cent had a documented mental health condition (ABS 2019b). It also found that a diagnosed mental health condition was a more prominent factor in younger age cohorts – present in 71.4 per cent of suicides in the 25–44-year-old cohort (ABS 2019b). The evidence indicates that effective treatment of mental illness, particularly major depression, has a positive impact on suicide rates.


Randomised controlled trials have found that effective mental health treatment includes psychosocial therapies such as cognitive behaviour therapy, group/family therapy, mentalisation-based therapies, dialectical behaviour therapy, interpersonal psychotherapy and narrative therapy (Burns et al. 2007).



The Commonwealth, states/territory governments and PHNs fund a range of mental health services for people with mental ill health. These include:

- Commonwealth-funded programs in primary care, the most significant being the Better Access Scheme, which, via a GP-led mental health treatment plan, facilitates up to 10 sessions with a mental health clinician billed under the Medicare Benefits Scheme
- Commonwealth funding to PHNs for mental health and suicide prevention services, with \$1.45 billion over three years from July 2019 to 2021–22. PHNs commission a suite of stepped care interventions in their catchment including access to free counselling for people with a diagnosed mental illness, through to self-referral low-intensity mental health supports
- state and territory-run clinical mental health services, which are delivered in hospital and community-based settings.
- All governments also fund relief packages in response to natural disasters that include additional mental health services.

Implementing the Fifth Plan reforms will also improve access to mental health services. This includes the commitment for Local Hospital Networks/Local Health Districts and PHNs to develop joint regional plans for the integrated planning and service delivery of mental health and suicide prevention services.



Best practice spotlight

Severe Tropical Cyclone Debbie Post Disaster Mental Health Recovery Program – Queensland

For many people, the two years following Severe Tropical Cyclone Debbie on 31 March 2017 were fraught with ongoing chaos and distress. For 74-year-old Sheryl, whose family home became uninhabitable due to flooding, the grief process, insurance battles, relationship crisis and physical health problems precipitated an overwhelming loss of hope for the future. Sheryl was increasingly vulnerable to mental ill-health, she had an elevated risk of suicide and unprocessed trauma from the death of her granddaughter by suicide in 2015, triggering her own experiences of childhood abuse.

The Queensland Government funded the Community Recovery Interagency Team to support Sheryl through a highly integrated care approach centred on shared referral, review and outreach processes, and highly agile wraparound engagement to support restoration of safety, as well as functional recovery. Sheryl received trauma-focused psychological therapies, clinical assessment and treatment, complex care coordination, group therapeutic intervention, functional recovery, family systemic support and grief and loss processing.

“ At first I was just overwhelmed by the destruction and loss of all our possessions. I started to feel that I couldn't start again and really didn't want to. I was offered counselling but couldn't go there. I have always been able to overcome traumas, trials and problems, even as a child, so I thought I could handle this. But after 8 months of trying, I realised I just needed to die. This was the only clear thought that filled my mind. I even worked out a plan.

Then one of the people from Community Recovery suggested I meet a lady counsellor. We met, and I sensed that she really understood what this devastation had done to ME as a person. I have to admit I was still reluctant to talk about myself. I believed I was not worth the trouble and undeserving of all the help we had been given. I hated myself because I was so weak and needed help.

Slowly I remembered my strengths. I realised that the overwhelming sadness, emptiness and fear were a response to trauma and not part of me. I stopped harming myself. The deep guilt I felt for not being able to help Tom and our sons rebuild the house lifted as my counsellor helped me see that I could use my computer skills to help ... and organise all the costs and finances. I no longer want to die or feel that I am of no use. I'm glad I finally accepted help and look forward with hope. ”

Sheryl

5: Consider the design and integration of government-funded crisis helplines

The Suicide Call Back Service and helplines such as Lifeline, MensLine Australia, Kids Helpline and the Beyond Blue Support Service¹⁰ help thousands of Australians in crisis each year by providing immediate support, information and referral. Helplines are especially important in supporting Australians living rurally and remotely and for people who find it difficult to access support during business hours.

Australia's specialised suicide helpline, the Suicide Call Back Service, received 37,341 calls in 2017-18, with 55 per cent of callers having a diagnosed mental health issue.¹¹ This helpline goes beyond immediate crisis support by offering six counselling sessions with a psychologist, social worker or counsellor (no referral required), a treatment plan and coordination with existing care for high needs callers.

While the effectiveness of helplines in preventing suicides is difficult to measure because of the anonymous nature of callers, there is evidence of positive outcomes. A major study of a crisis line in the United States found that intent to die was reduced by the end of the call (Gould et al. 2007); an Australian study of a youth crisis line found measurable reductions in suicidal ideation during the call (King et al. 2003); and a United Kingdom study found a crisis line was effective in reducing suicidal and self-harm ideation with callers (Tyson et al. 2016).

There is an opportunity for governments, as the funders of helplines, to work together to consider the design of helplines and their place within the system. Key areas of potential focus include: increasing awareness and entry points; better integration between helplines (including hot referrals¹²) and other access points for help; and assessing funding levels and co-investment opportunities so that calls do not go unanswered. The relationship between each helpline and helplines and digital help-seeking platforms such as Head to Health and ReachOut may also need to be strengthened. Given the likelihood of common callers, opportunities for better linkages with other helplines such as the National Alcohol and Drug Information Service and Gambling Helpline could also be explored.

Despite each helpline having a robust data capture system, mechanisms are not in place to allow data to be shared. The limited data available points to opportunities for improvement, including the following:¹³

- Demand is high and, in some cases, not able to be met. Unfortunately, 13,259 of the 37,341 calls received by the Suicide Call Back Service in 2017-18 could not be answered due to funding constraints.
- Callers often call multiple helplines to get the help they need. The lack of a single-entry point to triage the person to the most appropriate line risks the caller getting frustrated and disengaging.
- Many of the helplines refer people to the Suicide Call Back Service given it is able to offer counselling sessions to support people with complex mental health issues. However, these are not 'hot referrals', with the caller needing to hang up and call again.

10 Noting there are also a range of state and territory specific helplines, such as SuicideLine Victoria.

11 Internal data provided by On the Line, the provider of the Suicide Call Back Service to inform the drafting of this strategy.

12 Hot referrals are when the person is transferred from one service provider to another without the person having to hang up and call again.

A hot referral removes the barrier of the person having to make multiple phone calls.

13 Internal data provided by On the Line, the provider of the Suicide Call Back Service to inform the drafting of this strategy.

- Many callers call frequently and over extended periods. In 2017–18, more than half of all calls to the Suicide Call Back Service were from a small number of repeat callers with complex mental health needs. Lifeline also experiences this, reporting that many repeat callers have a diagnosed mental illness (Pirkis et al. 2015). Strategies to better support frequent callers are needed.
- Men are high users, which is thought to be driven by the after-hours offering, the mode of communication and the anonymity.
- Some callers are already receiving treatment in the public mental health system. They call to access additional help, normally after hours when their case manager and/or normal treatment options are unavailable.

The merits of potentially extending the role of helplines to provide short periods of counselling to callers who would benefit from it could also be explored. The Suicide Call Back Service's counselling sessions model could be evaluated to understand its effectiveness and the care outcomes for people who have used it. Within this model, coordination with the care the person is receiving in other settings will be essential. People who use crisis lines frequently should be high priority, with strategies for supporting them considered.

WHO's *Preventing suicide: a resource for establishing a crisis line* (WHO 2018) notes that opt-in follow-up calls to high-risk callers are both feasible and successful in preventing further suicidal behaviour. An American study found that 54 per cent of people who received a follow-up call indicated that the call had played a significant role in preventing them from taking their own life, and 59 per cent said the follow-up call had kept them safe (Gould et al. 2018). Australia's crisis helplines do not currently offer opt-in call backs (except the Suicide Call Back Service) and this is potentially a missed opportunity.

6: Consider extending existing aftercare services for people who have attempted suicide to include anyone in suicidal distress

Services for people in suicidal distress present an important opportunity to provide the support needed to change a person's trajectory – to prevent suicide attempts or suicide deaths. People should be able to access the help they need at any stage of distress, not just when an attempt is made. Unfortunately, GPs commonly report limited referral options for people in suicidal distress, and this experience is echoed by people with lived experience of suicidal behaviour.

It is difficult to accurately understand the availability and type of existing services across Australia. Feedback indicates that availability is patchy and only available in a few locations, what is available varies greatly and quality is inconsistent. Individual PHNs now fund services specifically in response to the needs of their local populations. These services commonly facilitate access to a psychologist with suicide-specific competencies on a sessional basis. A small number of the existing aftercare programs for people who have attempted suicide accept people in suicidal distress on a case-by-case basis.

To increase the availability of evidence-informed programs for people in suicidal distress, existing aftercare programs for people who have attempted to take their own life could be extended to this cohort. This enables the existing workforce and referral pathways to be harnessed, as well as the evidence on how to effectively work with people with suicidal behaviour that is being built through these programs. Servicing both cohorts can be relatively easily accommodated via minor adjustments to existing aftercare programs, including establishing stronger referral pathways with GPs and considering the optimal duration of the program for people in suicidal distress (approximately one month might be more appropriate).

7: Consider establishing evidence-informed non-clinical alternatives to emergency departments¹⁴

“ When you are in crisis, the emergency department seems like the only answer but, when you engage with the café there is a moment that you realise you just need support sometimes. ”

Customer at the Safe Haven Café at St Vincent's Hospital Melbourne¹⁴

There has been consistent feedback from people who have lived through a suicidal crisis that non-clinical, community-based, homelike environments with services staffed by a combination of peers and community support workers, where they feel safe, supported and genuinely understood, would best help them through a crisis and promote recovery.

The need to establish non-clinical evidence-informed services where compassionate care that is tailored to the person is recognised as important in recently released government suicide prevention strategies and frameworks. These services do not replace emergency departments or clinical mental health services (for those who need to access these services). They provide a different offering that can complement existing physical and mental health services or be an alternative pathway to help, support and referral, where that is appropriate.

Building on models that have demonstrated effectiveness overseas,¹⁵ governments have funded several pilots in Australia. These pilot programs provide an immediate peer-led compassionate response in a safe space. They focus on enabling the person to learn about their own response to crises, to develop self-management skills to help them maintain their mental health on an ongoing basis and explore what options may be available to support them. These pilots are captured Table 3. Robust outcome evaluations of these pilots will shape their future directions.

¹⁴ Safe Haven Café: Customer Experience Review of the Safe Haven Café at St Vincent's Hospital Melbourne, November 2019.

¹⁵ For example, the Safe Haven Café is modelled on a successful service operating in Aldershot, Hampshire, England since 2014. An evaluation of this service showed it had reduced social isolation for vulnerable people, helped them to maintain their mental health on an ongoing basis and helped some people avoid the need for National Health Service care including emergency department presentations and inpatient admissions (Wessex Academic Health Science Network 2017).



Table 3: Current pilots of non-clinical alternatives to emergency departments in Australia

Type	Description
Residential, lived experience-led recovery centre	In 2019–20 the Commonwealth provided \$1.25 million to Independent Community Living Australia to develop and trial a residential non-clinical suicide prevention and recovery centre in partnership with Roses in the Ocean. This new service will provide 24/7 peer-led support and care for people experiencing a suicide-related crisis in a homelike environment in Sydney.
	Red House at Brook Red Centre in Brisbane has based its program on the safe houses model by offering peer support mental health services.
'Safe haven' cafés	St Vincent's Hospital in inner city Melbourne established a safe haven café in March 2018.
	In its 2019–20 Budget, the Queensland Government committed \$10.8 million over four years to establish eight safe spaces based on the safe haven cafés model, staffed by mental health clinicians and lived experience peer support workers.
	The New South Wales Government has committed \$25.1 million to establish 20 safe haven cafés across New South Wales starting from July 2019, with local health districts working with people with lived experience to co-design local models.
Lived experience-led support groups	Lived experience-led support groups in suicide response in Western Australia hosted by TransFolk and in inner Sydney West by Off the Wall.

8: Consider new models of care in emergency departments that improve the experience for people with suicidal behaviour

People in suicidal distress will continue to present to emergency departments. When they do, they need to receive effective care and treatment and to be treated compassionately.

Recognising the constraints of emergency departments to treat people affected by suicidality, mental health and/or alcohol and other drug issues, some governments are investing in new models of care.

These models typically focus on an alternative triage and treatment pathway within the emergency department, changes to the staffing model to include mental health clinicians and people with lived experience and sensory changes to the physical environment, such as softer lighting. For example, the Victorian Government has invested \$100.5 million in six mental health hubs – separate 24-hour, short-stay units in emergency departments offering specialist care from psychiatrists, mental health nurses and social workers during times of crisis. People presenting with suicidality and other urgent mental health and alcohol and drug issues will be fast-tracked to these hubs for specialist, dedicated care.

9: Explore the effectiveness and best utilisation of digital technology for suicide prevention

The use of digital technology in suicide prevention in Australia and overseas is increasing rapidly and has considerable potential to have a positive impact on suicide rates. Digital technology includes machine learning, smartphone apps (including digital safety planning), wearable sensor-driven systems, computerised speech and facial emotions analysis, chatbots, automated cognitive behaviour therapy and digital decision-making tools (Vahabzadeh et al. 2016).

Digital technology is more accepted and accessible and has been found to play a key role in mental health literacy and help seeking. It is particularly utilised by youth, with, for example, 2.4 million people in 2018 visiting ReachOut's website to access youth-focused mental health and crisis-related information. A 2016 study found that among 1,953 people who had accessed ReachOut, 18.2 per cent were at 'high risk' of suicide based on their Suicide Ideation Questionnaire Score (ReachOut 2019).

For people living rurally and remotely, digital technology may help overcome trust and confidentiality issues while providing evidence-informed therapeutic content on demand in areas where access to services is difficult (Tighe et al. 2017). Digital technology may also present new opportunities to engage Aboriginal and Torres Strait Islander people, with 70 per cent of Aboriginal and Torres Strait Islander people owning a smartphone compared with 66 per cent in the overall population. Young Aboriginal and Torres Strait Islander people access social media almost 20 per cent more frequently than other Australian youth (McNair yellowSquares 2016).

To assist governments to invest effectively and to translate the outcomes of current pilots into practice, exploring the following questions would be insightful:


- How is digital technology safely being used in Australia and overseas to prevent suicide?
- What benefits does it offer, including its cost-effectiveness? Are there potential risks or unintended consequences?
- How could digital technology be better harnessed to strengthen current suicide prevention efforts?

10: Support evidence-informed systems to prevent the suicides of people receiving treatment in a public health service (encompassing inpatient and community care settings)

In 2017-18, tragically 24 Australians ended their life while being cared for in a public hospital (Productivity Commission 2020).

There is a very clear expectation from the community that their loved ones will be kept safe while receiving care, and around the world it is recognised that the suicides of people in care can be prevented.

Most states and territories have programs in place to improve care and outcomes for people receiving treatment who are at risk of suicide. Common components include: safe physical environments; leaders instilling the belief that suicide can be prevented for people in care; the enhancement of staff skills, attitudes and beliefs through high-quality training; a pathway of care that identifies those at risk; enhanced assessment, risk formulation and treatment planning; interventions that directly target suicidality; and safe, supported transitions of care (The Gold Coast Hospital and Health Services 2016).



Underpinning these programs is a continuous quality improvement framework, developed within a learning and 'just' culture where caring, competent and confident staff are supported to continuously improve and learn together. These programs are based on a systems-wide approach to eliminate gaps, with significant cultural and systems change required for improvements to be realised (Mokkenstorm et al. 2018). Many programs draw on overseas initiatives, with the evidence base for how to achieve 'zero suicides' in healthcare settings continuing to emerge.

What positive change will making these areas of focus a priority achieve?

- More Australians will be able to access evidence-informed help, treatment and care when in suicidal distress.
- When people do present at emergency departments, they will be treated compassionately and be provided with evidence-informed assessment, care and referral to appropriate services.
- For people who do not need immediate medical attention but need help to prevent or address suicidal behaviours, there will be a range of accessible, safe, evidence-informed places that will welcome them.
- Suicides of people receiving treatment from a public health service will decrease.

Potential future priorities

- Understanding assessment and treatment approaches for suicidal behaviour used in emergency departments around Australia and which approaches have led to better outcomes.
- Keeping a watching brief on the outcomes being achieved by the Scottish Distress Brief Intervention Program: Connecting Compassionate Support for people experiencing distress in Scotland. Early results from this initiative are positive and a pilot in Australia may be a future priority.
- Publicly reporting on the attempted suicides of people receiving care in a public health service, as well as suicides.
- Sharing best practice on eliminating the suicides of Australians being cared for in a public health service with the private sector and encouraging adoption of this best practice.
- Better understanding the relationship between alcohol and other drugs and suicidal behaviours and improving opportunities to intervene with and provide care to people with substance use disorders.
- Identifying associations between suicidal behaviours and prescription medications and taking appropriate regulatory steps to reduce potential harm.
- Encouraging the codesign of suicide prevention courses in recovery colleges around Australia.

The Western Australian Mental Health Commission and the Western Australian Police Force

The Mental Health-Co-Response (MH-CR) is a joint initiative between the WA Police Force, the WA Mental Health Commission and health service providers that coordinates a multiagency response to mental health-related circumstances. The initiative includes: calls for assistance where a mental health or welfare concern has been indicated; requests for advice, guidance or assistance from frontline police officers who suspect a member of the community is experiencing a mental health episode; and the admission of arrested people with mental health issues or a history of mental health intervention to the Perth Watch House who require assessment, monitoring and diversion pathways.

Over the course of the two-year trial (2016–2018) the following outcomes were achieved:

- Police Operations Centre: 20,149 tasks reviewed by the mental health practitioner including welfare checks, missing persons and mental health incidents.
- Mobile Teams: 2,907 mental health consumers were engaged/assessed by Co-Response teams
- Perth Watch House: 8,671 detainees screened by the mental health practitioner.

An independent evaluation of the trial showed benefits to resource allocation, the safety and wellbeing of officers and mental health consumers and increased interagency collaboration.

Interviews revealed that mental health consumers and their carers engaged positively with the MH-CR model and saw it as a significant improvement over the traditional crisis response used by police. In response to the success of the trial, in 2019 the MH-CR was expanded to cover the whole Perth metropolitan area.

‘ ...now the response teams can focus on their policing issues, and allow the mental health team, who have the capacity and capability of spending a lot more time, and have a lot more expertise because they have the practitioner with them, to actually deal with the jobs effectively and make a difference. ’

Participant in the evaluation

The independent evaluation is available at:
[http://www.parliament.wa.gov.au/publications/tailedpapers.nsf/displaypaper/4011830c6f17958a776124a04825830d0003e135/\\$file/tp-1830.pdf](http://www.parliament.wa.gov.au/publications/tailedpapers.nsf/displaypaper/4011830c6f17958a776124a04825830d0003e135/$file/tp-1830.pdf)



Enabling recovery through post-crisis aftercare and postvention

Why is this a priority?

It is widely accepted that a previous suicide attempt is a significant risk factor for suicide. Analysis of the 2,085 deaths by suicide reported between 2013 to 2015 to the Queensland Suicide Register found that 30 per cent had made a previous suicide attempt, with 16 per cent having attempted suicide in the year before their death (Leske 2019). The risk of attempting again is especially high in the days and weeks following discharge from emergency departments or inpatient units and can remain high for more than 12 months (Cooper et al. 2005; Wang et al. 2019).

It has been estimated that in 2017, 75,000 people attempted suicide in Australia (Slade et al. 2009).¹⁶ People with a lived experience of suicide report still feeling severe emotional pain after the attempt, as well as processing their feelings around survival itself. They report difficulties in actively seeking help or following up on the services available to them as they grapple with the raw emotions following their attempt. Research shows that within nine years of a suicide attempt, up to 12 per cent of people will have died by suicide (Owens et al. 2002).

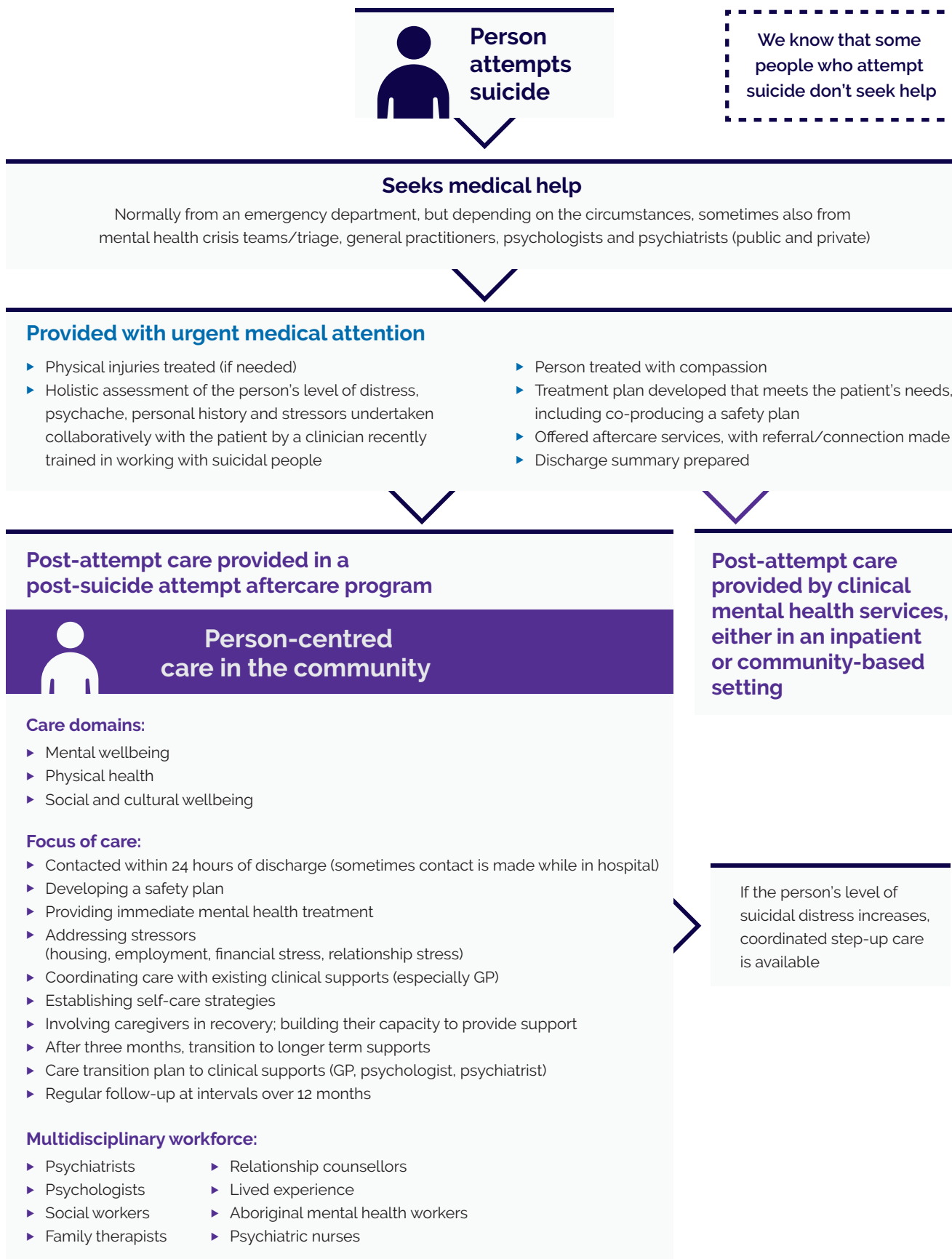
The evidence supports that immediate post-crisis aftercare and short periods of psychosocial support on discharge from an emergency department or admission to a hospital can reduce the reoccurrence of suicidal behaviours and enable a person to continue steps towards sustained mental health and wellbeing (De Leo et al. 2017). Assertive aftercare has been estimated to decrease further suicide attempts by up to 20 per cent (Krysinska et al. 2016).

While existing aftercare programs in Australia vary in their eligibility, design and scale, they generally include an integrated mix of psychosocial support and non-clinical assertive outreach. They operate for a period of approximately three months, with the first contact made within 24 hours of discharge and often involve the person's support system. They focus on connecting the person with immediate treatment and support services and help them to remain safe if the suicidal thoughts return by co-creating a safety plan.

Help is also provided to identify and resolve the factors that contributed to their suicide attempt – such as alcohol and drug use, gambling, postnatal depression, family violence, childhood trauma, employment and relationship challenges, isolation and loneliness. For people who have an underlying mental illness, treatment is provided by clinical mental health services and is tailored to the underlying issues leading to the suicidal behaviour. Figure 3 sets out best practice in aftercare models across Australia.

¹⁶ Estimated as a projection from 2007 data based on actual population growth to 2017; see Slade et al. 2009, p. 41.

Figure 3: Best practice in aftercare models across Australia





The time following a death by suicide also represents a critical time for compassionate, high-quality care. People who are bereaved by suicide are up to five times more likely to die by suicide themselves and are at risk of ongoing mental health problems (SANE Australia 2010). Children who are under 18 when a parent takes their life are three times as likely to go on to suicide (Willcox et al. 2010). Australian research in 2019 found that of the 3,127 suicides in 2017, 18 were suicides of people who had been bereaved by a suicide in their immediate network of family and friends (ABS 2019b). Suicide bereavement can also precipitate a suicide attempt in a suicidal person through enhanced awareness of means, reduced fear of death or social modelling (Pitman et al. 2016).

What are the areas of focus?

11: Increase the availability of aftercare programs following a suicide attempt

“ My family felt powerless and uninformed when dealing with the health system during my aunt’s many attempts. She was not in a position to comprehend the support she was being offered or needed. They were not given follow-up support after discharge and did not have the knowledge or assertiveness to ask for anything more than they were provided – which was not enough, not nearly enough. ”

39-year-old woman from New South Wales whose aunt died by suicide by suicide three years

Widespread access to evidence-informed, person-led aftercare at the intensity the person requires following a suicide attempt is inconsistent across Australia. While access has improved significantly in recent years through government funding, many of these programs are in pilot stage with limited scale, narrow eligibility criteria and referral pathways and are primarily in major cities and/or regional centres.

While there are positive stories, some people still have negative experiences with the care they receive following a suicide attempt. They report that care pathways were not always clear or easy to access, care is not offered consistently and that the quality, amount and duration varies. They report a lack of connection between services and clinicians, meaning that they need to tell their story again and again (NHMRC Centre of Research Excellence in Suicide Prevention n.d.).

Responsibility for funding aftercare programs is currently shared between the Commonwealth, states/territories and PHNs. Limited joint service planning between the three funders has led to missed opportunities, including to ensure consistency in approach to aftercare within geographic areas, locating services in areas of highest need and programs with the strongest evidence being prioritised and scaled.

In its 2018–19 Budget, the Commonwealth invested \$37.6 million for Beyond Blue's The Way Back Support Service to be implemented in selected PHN regions across Australia. This national rollout, which includes co-contributions from states and territories, provides an opportunity to consider how best to achieve a system of aftercare in Australia. It could evolve the current fragmented approach into a systematic and integrated system, where people who have attempted suicide are offered an evidence-informed aftercare program as part of standard care. Aftercare programs should also be integrated with clinical mental health services for people who need both services.

Although the evidence base for aftercare programs has grown rapidly in recent years, there is still much that is unknown, particularly around the longer term outcomes for people who take up these programs. The Commonwealth has funded an outcome evaluation of The Way Back Support Service, which is due to be publicly released in 2020. This evaluation will considerably advance the international evidence base for aftercare programs.

Applying the following best practice principles will increase the effectiveness of aftercare programs:

- **Timely:** Ideally the first connection should be made while the person is still in the emergency department or inpatient setting. Contact should then be made again within 24 hours of the person's last contact with the health system.
- **Psychosocial:** Psychosocial assessment prior to discharge should be used to determine the mix of clinical, social, personal and family/personal supports the person needs. Repeating the psychosocial assessment at key points throughout the program to ensure care needs are being met is important.

- **Person-led:** The service should be flexible, responsive and culturally safe. Face-to-face contact should be in locations where the person feels safe and supported (for example, in the person's home).
- **Availability:** As much as possible, aftercare should be available both during and outside of core business hours.
- **Duration:** Aftercare should be provided for a minimum of three months, with flexibility to extend based on what is best for the person. Low-intensity options to maintain the connection over longer periods should be utilised.
- **Safety planning:** Co-produced safety plans at all points of the person's journey are important, recognising that risk of suicide is often fluid and the evidence that safety planning is effective in reducing suicidal behaviours (Stanley et al. 2016).
- **Network of care:** As well as connection with new services, aftercare should involve the person's existing network of clinical support such as their GP, psychologist and/or psychiatrist. To facilitate effective transitions of care, contact should be made with these clinicians at the start and conclusion of the program. Integration with other services that support recovery should also be a focus.
- **Support network:** Programs need to be inclusive of the person's support network (however this looks), with a focus on building their confidence and skills to support the person they love and in their own self-care. This could include dedicated sessions specifically for the person's support network by appropriately trained clinicians.
- **Lived experience:** Appropriately trained people with lived experience of suicide should be included in the aftercare team and adequately supported to build their competency and in their self-care.
- **Clinical governance:** The clinical components of the service should have appropriate clinical governance. There should also be agreed pathways to facilitate stepped-up care, should a person's risk escalate.



Most of the programs currently funded by governments cease after three months (with some flexibility). With the evidence indicating that the risk of a future suicide attempt remains high for up to 12 months (Cooper et al. 2005; Wang et al. 2019), consideration of the optimal timeframe for support and the use of technological-enabled options as a lower cost alternative to extending care is needed. There are several pilots underway with promising results that use postcards, personalised letters, emails and/or text messages to keep the person connected over 12–24 months.

While the current focus on ensuring people who present to emergency departments or are discharged after an inpatient stay are offered aftercare remains a priority, more people could be supported to recover by expanding referral pathways to include mental health triage, crisis helplines, ambulance services, community mental health, alcohol and other drug services and GPs. It is also noted that current aftercare models have been designed for adults and there is a need to pilot models for younger people.

Families and carers can play a valuable role in helping a loved one recover after a suicide attempt. However, they report that people are at times discharged home without loved ones being informed and inadequate communication about what their role will be in supporting the person at home (Leggatt & Cavill 2010). Australian research undertaken in 2019 with 758 people providing care to a family member or friend after a suicide attempt found that 65 per cent did not receive any information about how to care for their loved one from the treating health professional and only 18 per cent felt supported to provide care (Coker et al. 2019). Many sought information online, from support groups and/or their own psychological supports. Families and friends need more information about how to best support their loved one, where to go for help and what action to take in the event of another crisis or attempt. There is an opportunity for governments to work together to develop a co-designed online support package to build the capability and confidence of families and friends to help a loved one recover.

“ Actually [the health professional] sent me a link that was quite good. She said, I'm sure this has had an impact on your and yeah, she did send me a link that was quite good. It was sort of to the point of you know, that the carer needs caring too sometimes...¹⁷ ”

Boyd, metropolitan New South Wales, caring for a friend after a suicide attempt

It is acknowledged that this caring role can have a profound emotional, financial and social impact on family and friends. Many report that the need to fill the gap of professional care when their loved one returned home, and to maintain a high sense of vigilance, impacted on their wellbeing and their ability to meet their other roles and responsibilities (Coker et al. 2019). Providing support to families and friends and building their skills and confidence in self-care is important.

The contribution of non-government organisations that also fund aftercare programs is acknowledged. This includes Lifeline's Eclipse program, which is an eight-week support group for people who have attempted suicide and is based on a North American service for which there is an emerging evidence base (Hom et al. 2018).

¹⁷ Sourced from Coker et al. 2019

The Way Back Support Service, Commonwealth

The Way Back Support Service is an aftercare program for people who have been discharged from hospital following a suicide attempt. It starts with a support coordinator contacting people referred to the service from an emergency department and developing a safety plan with them. From there, the support coordinator guides the person through the critical period immediately following their suicide attempt. The program is personalised to meet individual needs and can include everything from linking people to clinical care during elevated periods of risk, to referrals to community-based services such as financial or relationship counselling.

The Way Back Support Service was developed by Beyond Blue in 2013 in partnership with Anglicare Northern Territory, NT Health, the Royal Darwin Hospital Crisis Assessment and Triage Team and Cowdy Ward. The program was developed in response to growing evidence that the months immediately after a suicide attempt or suicidal crisis is a vulnerable time for someone in crisis and that non-clinical aftercare has proven effective in helping reduce suicidal behaviour and suicidal ideation.

“ It saved my life basically. It really did. If people use it in the right way. It was very beneficial to me. I haven't had a drink in eight months. I still get depressed, but I know how to get out of it now. They saved my life it was so good. ”

Person with lived experience who used The Way Back Support Service in Newcastle

Beyond Blue initially trialled The Way Back Support Service in Darwin from 2014.

An independent evaluation conducted on The Way Back Support Service Darwin trial site between June 2014 and October 2015 found that the service received 122 referrals and provided care to support 87 clients during that time. It found high rates of participation and engagement in the program with 78 per cent of clients participating in the intensive intervention stream of the service, receiving support for 86–88 days on average. The evaluation found that the service model was feasible in meeting the needs of people who had attempted suicide, or experienced suicidal crisis, and played an important role in filling a critical gap in the service system.

Subsequent trials were opened in the Australian Capital Territory and the Hunter region of New South Wales in 2016. For the ACT, referrals are received from clinical teams at Canberra's two public hospitals. The aim is for a fast response (within 24 hours), and ideally to meet people prior to discharge.

“ Acknowledgment that I wished my suicide attempt had been successful, making time to allow that as part of The Way Back process. Supporting and connecting with other services – invaluable with Centrelink. ”

Person with lived experience who used The Way Back Support Service in the ACT

12: Recognise the importance of postvention bereavement services in supporting individuals and families to recover

“ I think suicide is like a stone being thrown into a calm pond. You only see the surface ripples but not what is lurking beneath the waves and the damage being done. It's those that have lasting effects. I miss him even after 17 years and even though I no longer feel guilt, I feel his loss and I still ache for him and what might have been. ”

40-year-old West Australian woman whose partner died by suicide 17 years ago.

Postvention bereavement services to support individuals and communities to recover is another important component in a systems-based approach to suicide prevention. Grief following a suicide can be intense, and the emotions experienced in the aftermath – particularly around stigma and isolation – can differ considerably from those felt following other types of death. The effect is similar whether the bereaved were blood related or not (Pitman et al. 2016). Recovery can take time, with 2016 Australian research finding evidence that high levels of distress can last between one to 58 years after the suicide (Maple et al. 2016).

Bereavement services that are specific to suicide are important because there is evidence that bereavement by suicide is different from other types of bereavement due to the potential preventability of the death, the stigmatisation of suicide and the traumatising nature of self-inflicted death (Survivors of Suicide Loss Task Force 2015).

The most significant Australian-based evidence for postvention bereavement services is a 2017 independent evaluation of StandBy – Support After Suicide, which compared 454 people who had accessed StandBy with those who had received support from other sources (such as a support group, GP or psychologist) or no support at all. It found that those who had received postvention services:

- had reduced the risk of suicide (38 per cent compared with 63 per cent)
- had fewer mental health concerns (38 per cent compared with 74 per cent)
- were significantly less likely to experience a loss of social support and experience social loneliness and loneliness (28 per cent compared with 50 per cent)
- had fewer instances of difficulty sleeping, financial distress, family breakdown or problems in the workplace (Gehrmann et al. 2018).

The Commonwealth is the major funder of postvention bereavement support services, funding StandBy Support Services to provide non-clinical support services to approximately 30 per cent of the Australian population. The Commonwealth has also funded the National Indigenous Critical Response for culturally safe non-clinical postvention bereavement services. Some states and territories and PHNs also fund postvention bereavement services to fill local service gaps and/or due to historical arrangements.

With regard to postvention bereavement services, there are opportunities to consider:

- reviewing funding arrangements and undertaking joint planning to increase coverage according to population distribution and need
- putting systems in place to enable automatic notification from police to postvention bereavement service providers to ensure everyone who needs help is offered it immediately
- growing the evidence base by evaluating current services, with findings published to improve practice
- how best to incorporate people with a lived experience of being bereaved by suicide in the delivery of these programs
- developing postvention bereavement services outside of the school environment that are tailored specifically to children and young people bereaved by suicide
- developing protocols and models for postvention bereavement for workplaces.

Best practice spotlight

The South Australian Suicide Postvention Referral Mechanism

Country SA PHN led a working party to identify the best mechanism for South Australia Police (SAPOL) to make immediate referrals to postvention service providers when there has been a suicide. The working party comprised Country SA PHN, SAPOL, StandBy Response Service, Living Beyond Suicide, the National Indigenous Critical Response Service and Adelaide PHN.

This work resulted in a new formalised SA Postvention Referral Mechanism that includes:

- a dedicated SAPOL officer that coordinates notifications and information exchanges between SAPOL and postvention providers
- families now being contacted and advised of the coronial process and postvention providers within 24–48 hours (permission is gained for referral to the postvention provider)
- notification by SAPOL to the postvention provider within 24 hours
- mandatory collection of ethnicity on the police form to inform culturally appropriate support
- one referral card in all police cars – replacing four service provider cards
- training by postvention providers for all South Australian police cadets.

‘ We have received some really good feedback from families since we have been using the new referral mechanism and that’s probably the best indicator for us that this system can and is already making a difference. ’

*Trevor Rea, Detective Senior Sergeant,
South Australian Police*

What positive change will making these areas of focus a priority achieve?

- More people who attempt suicide and have contact with the health system will be offered evidence-informed aftercare to help them resolve their immediate crisis and connect them with longer term supports.
- More individuals, families and communities will receive evidence-informed postvention bereavement services to support their recovery.

Potential future priorities

- For people who need it, flexibility to extend the duration of aftercare programs following a suicide attempt to approximately one year – in line with the high-risk period following a suicide attempt.
- Co-designing and piloting post-attempt aftercare programs for young people, acknowledging that current models are designed for adults.
- Better understanding the diversity of needs of priority populations with respect to aftercare and co-designing and piloting different models (noting some of this work has already started with the North Western Melbourne PHN piloting a model of aftercare for those in the LGBTIQ+ community impacted by a suicide attempt).
- Seek to influence private health insurers and private hospitals to offer post-attempt aftercare by potentially funding members' participation in a public aftercare program.

Sian's story

I am a mother of two gorgeous boys. Sadly in 2016 I lost my 21-year-old son to suicide. He was good looking, sporty, fit, had eyes that twinkled and a beautiful heart.

The horror of the ensuing days, weeks, months and now years is burnt inside me. The grief and sadness of what is lost is too big to fully understand.

I was lucky enough to be referred to StandBy support services by the attending emergency service workers, and I was contacted by them the next day. I carry the same StandBy support services card in my wallet to this day. My GP and her staff have shown me unending compassion and understanding, and also referred me to a great local psychologist. I know I need help from these wonderful professionals along with some medication to deal with this tremendous grief, and also the PTSD, but I am thankful it is available to allow me to put one foot in front of the other. I want ALL grieving partners and family to have the same support offered to them.

I don't just think, I know how important 'like-for-like' peer contact from someone with lived experience is when you feel so emotionally isolated. Being bereaved by suicide means, by travelling down a path you would never choose, you have an empathy, understanding and authenticity that cannot be learnt any other way. I know the comfort I have felt, and that I have also been able to give, by being able to talk honestly and openly with people who have the same lived experience. Sometimes words aren't necessary when you know another person really understands how you feel inside. Sadly, it was only this year that I was able to find and also share lived experience through the wonderful Roses in the Ocean program. This type of collaboration is both crucial and critical. I am determined to become more educated and informed, and therefore educate and inform more.

Losing a child to suicide is a grief unlike no other. Funding for resources and training is vital to enable dedicated and passionate likeminded people make a difference. Advances in digital tools, community awareness and knowledge sharing, and initiatives like the one in Geelong, Victoria that is piloting pairing a paramedic and a specialist mental health nurse, show the importance of continued and increased funding to support these essential services. Some people say 'you are brave' – maybe I am, but this is because those with lived experience have a knowledge and a passion that they gladly share to make a difference.

Sian, 53, Queensland

Community-driven Aboriginal and Torres Strait Islander suicide prevention

Why is this a priority?

6 In the Indigenous community we hear of somebody weekly associated with our mob. My cousin brother went to get help from the hospital and because they wanted him to see a psychiatrist which many Indigenous people associate with being mad or crazy he left. Sometimes it's about having appropriate places to go in times of need. ,

38-year-old Aboriginal and Torres Strait Islander woman from Western Australia

In the past 50 years suicide has emerged as a major cause of premature Aboriginal and Torres Strait Islander mortality and has significant implications for the overall social and emotional wellbeing of these communities. In 2018, 169 Aboriginal and Torres Strait Islander people died from suicide, with the standardised death rate by suicide for Aboriginal and Torres Strait Islander people 24.1 deaths per 100,000 people (ABS 2019a). Most Aboriginal and Torres Strait Islander people who die by suicide are men; however, there is an ongoing concern for the increasing number of women and youth who die by suicide (ABS 2019a).

The impact of suicide in close-knit communities and through familial and social networks can be particularly devastating and far-reaching. Aboriginal and Torres Strait Islander suicide is often described as 'different' from the suicide of a non-Indigenous person. This is because it needs to be understood in the context of deeper 'structural' social and economic challenges stemming from colonisation, as well as challenges affecting individuals, especially across life's transition points (Tatz 1999).

In 2015 the Commonwealth funded a program to build an evidence base for Indigenous-specific and strengths-based suicide prevention programs and policies. The 2016 ATSIPEP report, *Solutions that work: what the evidence and our people tell us*, articulated a series of success factors to guide efforts (see Table 4).



Table 4: Summary of success factors identified in ATSIPEP

Factor	Target	Tools/actions
Universal* / Indigenous community-wide	Primordial prevention	<ul style="list-style-type: none"> Addressing community challenges, poverty, social determinants of health Cultural elements – building identity, social and emotional wellbeing, healing Alcohol/drug use reduction
	Primary prevention	<ul style="list-style-type: none"> Gatekeeper training – Indigenous-specific Awareness-raising programs about suicide risk Reducing access to lethal means of suicide Training of frontline staff/GPs in detecting depression and suicide risk E-health services, online information, crisis helplines and chat services Responsible suicide reporting by the media
Selective – at-risk groups	School age	<ul style="list-style-type: none"> School-based peer support and mental health literacy programs Culture being taught in schools
	Young people	<ul style="list-style-type: none"> Peer-to-peer mentoring, and education and leadership on suicide prevention Programs to engage/divert, including sport Connecting to culture/country/Elders Providing hope for the future – education and preparing for employment
Indicated – at-risk individuals	Clinical elements	<ul style="list-style-type: none"> Access to counsellors and other mental health support 24/7 availability Awareness of critical risk periods and responsiveness at those times Crisis response teams after a suicide (postvention) Continuing care and assertive outreach following a hospital admission for a suicide attempt Clear referral pathways Time protocols High-quality and culturally appropriate treatments Cultural competence of staff and mandatory training requirements
Common elements	Community leadership/ cultural framework	<ul style="list-style-type: none"> Community empowerment, development, ownership – community-specific responses Involvement of Elders Cultural framework
	Provider	<ul style="list-style-type: none"> Partnerships with community organisations and Aboriginal community-controlled health services Employment of community members (peer workforce) Indicators for evaluation Cross-agency collaboration Data collections Dissemination of learnings

Adapted from Dudgeon et al. 2016

* In the ATSIPEP report, 'universal' is used to indicate community-wide responses, not population-wide responses as the term usually indicates.

Leilani's story

My story begins in childhood whilst growing up with a mother who experienced severe mental illness and alcoholism. We grew up in low socio-economic background and often went without. My mother had experienced her own trauma as a young person, and this continued to affect her after having three children. At different times growing up I know that my mum sought help to deal with her issues, and other times they were too much for her. This resulted in her regularly self-harming and us being exposed to her breakdowns while living with her. We spent time temporarily with child safety while she sought help when things were overwhelming for her. The longest period was after my mother was charged following a serious incident. I was also impacted by several traumatic events centred in violence and alcohol abuse.

Having lost my mum to suicide when I was 10 years of age and then living in a couple of different family situations I was separated from my sisters and found myself with my Nan. Not long after that she passed away after many years of ill health associated with most Aboriginal people who die at a young age in this country. Losing the two most significant people in my life impacted me more than I realised. My first attempt to end my life was at 13 then again at 15 and later at 22. I was a bit of a closed book and only shared little bits of information with psychologists who tried to help me. I knew not to give too much information away due to my time in the care of child safety and didn't want my thoughts and feelings to be used against me.

It was at 22 when everything started to consume my life in a negative way. I was diagnosed with a major depressive illness and sought help. Whilst initially being put on a waiting list following my suicide attempt, I had to be real and told them about what had happened, at which point I was able to engage the next day with a counsellor from a local women's service. Most of this was kept secret to people in my life except a few family members and friends along with my workplace as I couldn't function in the workplace so needed time off.

That was both good and bad because I was left with my thoughts. Thoughts of dying, who would come to my funeral, packing up my stuff and leaving instructions and genuinely feeling like the world would be a better place without me in it.

During my time in counselling I learnt that I was still impacted by so much from my childhood and that whilst I had moved on with life it was at the point where I had to actually deal with things so that I could move forward and find happiness. It wasn't an easy journey and I had to learn how to ride the roller coaster of ups and downs with my emotions so that I could stay safe at times when I felt so low that I didn't want to be alive anymore.

I have found that for various reasons I am now working in the suicide prevention and mental health sector and specialising in Aboriginal and Torres Strait Islander lived experience, advocacy and reform. After having my daughter, I travelled well with my mental health and found in the last few years that I have been diagnosed with depression and anxiety again. I'm actively managing my mental health and wellbeing. I have a support network and appropriate strategies in place to deal with my illness. I find strength in sharing my lived experience with others and mostly doing everything I can that's humanly possible to make sure that my people live.

Particularly showing my mob that even with terrible circumstances in life, with hard work and tough decisions to make changes, suicide doesn't have to be your only choice. I struggle with overwhelming grief and the loss of my mum, my best friend, my younger sister and countless others, yet the fact that I am still here and making a brighter future for my daughter keeps me going and wanting to be alive. We need to remember that many who work in our sector continue to be impacted by not just their work experiences but their family and cultural obligations and our workplaces need to better support and work with our people to be on the frontline and prioritise their own mental, emotional and physical wellbeing. Fundamentally this is often forgotten when programs and services are funded without the allowance of adequate time and the ongoing grief and loss our communities face.

Leilani Darwin, 38, Queensland



What are the areas of focus?

13: Support a new national Aboriginal and Torres Strait Islander suicide prevention strategy and implementation plan

The need for a dedicated national strategy was one of the key recommendations from the 2nd National Aboriginal and Torres Strait Islander Suicide Prevention Conference. Advice from Elders and experts in Aboriginal and Torres Strait Islander suicide prevention is that the high occurrence and impact of suicide in Aboriginal and Torres Strait Islander communities is a significant national concern, greater integration is required with broader responses to mental health and social and emotional wellbeing and that a dedicated national strategy would focus, accelerate and coordinate efforts, including expanding the evidence base for effective interventions.

A new national strategy and implementation plan would need to be integrated with the *National strategy framework for Aboriginal and Torres Strait Islander peoples' mental health and social and emotional wellbeing* (2017), build on the *National Aboriginal and Torres Strait Islander suicide prevention strategy* (2013) and be guided by the Gayaa Dhuwi (Proud Spirit) Declaration. It should also incorporate advances in the evidence base from the Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project, the National Suicide Prevention Trial Sites that focus on Aboriginal and Torres Strait Islander people and the ongoing work of the Centre for Best Practice in Aboriginal and Torres Strait Islander Suicide Prevention and research funded through the Million Minds Research Fund.

It would be important that drafting is led by an Indigenous mental health and suicide prevention leadership body, with Elders, communities and Aboriginal and Torres Strait Islander people with lived experience of suicidal behaviour empowered to co-produce at all stages of the plan's development.

14: Support culturally safe post-suicide attempt aftercare models

To support Aboriginal and Torres Strait Islander people receiving culturally safe and responsive care following a suicide attempt, there is a need to develop culturally safe aftercare models. While these would be informed by the mainstream aftercare models, models that are developed by Aboriginal and Torres Strait Islander people for Aboriginal and Torres Strait Islander people are needed. There are distinct cultural differences between non-Aboriginal and Aboriginal and Torres Strait Islander people (and also between Aboriginal and Torres Strait Islander groups), and these differences must be taken into account in the way care and support is provided.

15: Support clinically and culturally appropriate risk assessment tools and resources to support the assessment of risk of suicide in Aboriginal and Torres Strait Islander people

Approaches to suicide risk assessment have evolved to compassionate, client-oriented, systematic explorations of the person's current suicidal status and needs to inform a commensurate management care and safety plan, co-developed with the person. In line with this, there are opportunities to develop culturally appropriate risk assessment tools and resources for assessing suicide risk in Aboriginal and Torres Strait Islander people.

The Centre for Best Practice in Aboriginal and Torres Strait Islander Suicide Prevention and researchers funded through the Million Minds Research Fund have begun a review of existing tools and resources used for assessing risk of suicide in consultation with clinical and cultural advisers. The findings of this review will identify existing gaps in assessment tools and resources to inform the development, testing and validation of culturally appropriate risk assessment tools to address suicide risk in Aboriginal and Torres Strait Islander people including specific vulnerable groups including LGBTIQ populations, people with lived experience and young people.

What positive change will making these areas of focus a priority achieve?

- At a future point, Aboriginal and Torres Strait Islander people will have a dedicated national plan for suicide prevention endorsed by every Health Minister across Australia.
- Following a suicide attempt, more Aboriginal and Torres Strait Islander people will be able to access culturally appropriate aftercare programs.
- There will be culturally appropriate evidence-informed tools and resources to support suicide risk assessment for Aboriginal and Torres Strait Islander people.

Potential future priorities

- The implementation of the new national strategy for Aboriginal and Torres Strait Islander suicide prevention will shape future priorities.

Kumpa Kiira Suicide Prevention Project, NSW Ministry of Health

Coomoalla Health Aboriginal Corporation (CHAC) has developed and delivered the Kumpa Kiira Suicide Prevention Project as part of the NSW Suicide Prevention Fund. This innovative health promotion program seeks to prevent suicide by engaging Aboriginal people across the lifespan through a range of activities grounded in culture and community connection.

CHAC provides a range of health services to address the health needs of Aboriginal people in the Wentworth and Balranald regions of New South Wales. The communities serviced by CHAC experience a range of complex issues including domestic violence, drug and alcohol issues, and mental and physical health concerns. The region has also lost a number of Aboriginal people to suicide.

The Kumpa Kiira Project employs a team leader and two Aboriginal suicide prevention workers. These staff are supported in their roles by a dedicated social and emotional wellbeing worker who provides one-on-one support and counselling to clients. Community engagement has been a key component of this work, with a focus on youth and Elders.

The Kumpa Kiira Project seeks to engage Aboriginal youth through its youth groups for men and for women. The project's Aboriginal suicide prevention workers have created partnerships with local schools to support the project. The youth groups have used art, music and other activities to engage young Aboriginal people with culture and to support their connection to community. A drumming group has recently been established that connects disengaged youth through music.

The project has also engaged local GPs in the Wentworth and Balranald regions of New South Wales with formal upskilling and advice on how to identify and manage suicide risk and postvention. The Local Health District and the PHN are engaged by the project to support Aboriginal clients seeking mental health services.

Priority foundations

Building and supporting a competent, compassionate workforce

Why is this a priority?

Reflective of the multiple factors that influence suicidal behaviour and its complex nature, Australia's suicide prevention workforce spans multiple disciplines and occupations (see Table 5). Some groups in this diverse workforce, such as relationship and financial counsellors, are only just emerging as the sector itself matures. For some of the workforce, working with people experiencing suicidal behaviour is their primary focus and, for others, it is one of many aspects of their day.

Table 5: The suicide prevention workforce in Australia

Category	Roles
Clinical professions	Psychologists, psychiatrists, nurses (including emergency department nurses, mental health nurses, mental health nurse practitioners, community-home visiting nurses, midwives, maternal and child health nurses and general practice nurses), GPs, emergency department clinicians, paramedics, alcohol and other drug workers, allied health professionals such as social workers (including mental health-accredited social workers) and pharmacists
Non-clinical professions	Police, counsellors, social workers, family therapists, public health workers, health promotion practitioners, family violence workers and crisis helpline workers
Peer/lived experience workers	People with lived experience of suicidal behaviour who are specifically employed or volunteer in peer roles. This could be in a range of settings, including suicide-specific services, mental health services or alcohol and other drug services
Community connectors	People who hold positions where they are in regular contact with community members such as general practice receptionists, pharmacists, teachers, sports coaches, retail workers, council workers and volunteers
Families, friends and carers	If supported with the right skills, families, friends and carers can play an invaluable role in identifying people at risk and supporting them to find help
Policymakers, commissioners and advisors	Staff in government departments, PHNs, peak suicide prevention organisations, researchers, evaluators and data analysts

As a component in a systems-based approach to suicide prevention, the suicide prevention workforce needs to be supported throughout their careers to build and maintain their competency through regular access to suicide-specific training. Training needs to be evidence-informed and tailored to the competencies each workforce needs to perform their role. It should be coupled with support to transition learnt skills into practice, with, where appropriate, local systems within health services, practices and organisations supporting this translation. Training also needs to address that working with people in distress is challenging and orientate the workforce towards processes and resources they can access to help manage these challenges and practise self-care. Repeating training at regular intervals is also important to maintain competency, especially because assessing suicide risk in clinical practice is challenging, with research ongoing to improve risk assessment approaches (Large 2018).

A uniform approach to building competency delivered through modularised training with the same underlying approach, focus and tools is important in achieving consistency across multiple workforces and facilitates training being cost-effectively delivered at scale. It also results in better outcomes for the person experiencing the suicidal behaviour, with each professional they seek help from using the same approach, risk assessment and mitigation tool and safety plan. A uniform approach also increases integration between services, which aids step-up and step-down care and multidisciplinary approaches.

For clinicians, training must focus on building their competency in suicide risk assessment and mitigation, especially in co-producing a safety plan. The evidence for co-produced safety plans continues to strengthen, with a 2018 American study finding that undertaking safety planning with emergency department patients with suicidal behaviour, coupled with brief telephone follow-up, reduced suicidal behaviour by 50 per cent over six months (Stanley et al. 2018). Safety plans are available as apps, empowering ownership by the person and facilitating regular updating and sharing with others, including clinicians, family and friends.

Another essential element of training is building empathetic, compassionate and effective communication skills. A compassionate approach requires an understanding of where the person came from, what they are connected to, how they got to where they are now and how they can move forward. People with lived experience report that compassionate care is vital to their successful recovery.

It is important to acknowledge that the suicide prevention workforce has valuable practice knowledge to share from their first-hand experiences in working with people with suicidal behaviours. Also important is to acknowledge and plan for the personal impact of working with people with suicidal behaviour (Hawgood & De Leo 2015). This includes well-defined scope-of-practice models with clear referral pathways for escalation if required, appropriate mentoring, supervision and de-briefing and support for self-care. In addition to people employed in specifically in peer roles, many people in the workforce may also have their own lived experience of suicidal behaviour.

“ In working professionally with people who are suicidal for 20 plus years, I partake in clinical supervision and work with a team that helps by being able to debrief, yet some days I feel sad and slightly depressed and at the time I am unsure why. I usually realise later that it was after I have had multiple suicide assessments or a story that stays with me more than others. My point is that no matter how experienced and supported we are, hearing and knowing of people who are suicidal has an insidious effect. ”

54-year-old clinician from New South Wales

At the time of drafting this strategy, the Commonwealth Department of Health, in consultation with the National Mental Health Commission, had begun developing a new mental health workforce strategy for Australia. This new strategy will encompass the suicide prevention workforce, with the areas of focus in this strategy a key input.

Best practice spotlight

Connecting with People, South Australia and Tasmania

Connecting with People (CwP) was developed in the United Kingdom by 4 Mental Health Limited (4MH) and has been adapted for delivery in Australia. The CwP training approach is designed to improve the response given to people in distress or at risk of suicide. CwP is informed by evidence-based principles, lived experience and clinical expertise and aims to increase the use of a compassionate approach, reduce stigma and enhance participants' ability to compassionately respond to someone who has suicidal thoughts or following self-harm.

Underpinning CwP is a philosophy that suicide is not inevitable. CwP offers a new narrative that moves away from characterising, quantifying and managing risk, towards placing greater focus on compassion, safeguarding and co-designed safety plans. CwP offers a clinical governance framework and the appropriate tools (including the SAFE-Tool) to build knowledge and understanding, and confidence to support people in suicidal distress.

CwP offers a common language to describe the nature and intent of suicidal thoughts, enabling greater clarity, accuracy and consistency between clinicians, consumers, families, carers and organisations, as well as improving the quality of documentation.

South Australia and Tasmania have invested in accredited trainers to deliver the CwP approach to suicide mitigation and response. Trainers have been drawn from various agencies and areas including health departments, justice, education, corrections, mental health consumers and carers, child and youth services and first responders.

The *South Australian suicide prevention plan 2017–2021* and the *Suicide prevention workforce development and training plan for Tasmania 2016–2020* provide the policy context for delivering the training in the respective jurisdictions.

In March 2019 the new Mental Health Hospital in the Home team in southern Tasmania was the first mental health team to receive CwP training. Tasmania's public mental health services continue to be the focus for the CwP rollout.

The partnership between South Australian Prison Health, the University of SA, the Office of the Chief Psychiatrist and the Department of Correctional Services has been recognised for efforts to support a compassionate, consistent approach to interventions within the South Australian correctional system.

The Chief Psychiatrists of Tasmania and South Australia, with the University of SA and the Tasmanian Department of Health, have developed a community of practice approach with 4MH and demonstrate a collegial approach to learning and ongoing professional development through the CwP approach.

What are the areas of focus?

16: Better target workforce development initiatives

16a: Support evidence-informed suicide prevention training for general practice and updated suicide prevention-related content on HealthPathways

With approximately 88 per cent of Australians visiting a GP at least once a year (Britt et al. 2008), GPs are in a unique position to identify warning signs for suicide and provide care and referral. Feedback from GPs indicates they need to be better supported with high-quality suicide-specific training and referral pathways into accessible, timely mental health and suicide prevention services.

Suicide prevention training for GPs has multiple funders: the Commonwealth through PHNs and the 12 national trial sites; and states and territories through their own programs. Some training is accredited by the Royal Australian College of General Practitioners and recognised for continuing professional development points. Recognising their role in working with suicidal patients and supporting changes to systems within practices, some training also includes modules/content for practice staff.

Training for general practice needs to relate to the suicide prevention content on HealthPathways, the software tool most general practices use to assess, manage and refer patients. GPs indicate there are opportunities to improve the suicide-related content on HealthPathways to facilitate better assessment and referral to care. PHNs are responsible for HealthPathways content.

16b: Support emergency department clinicians in contemporary risk mitigation and safety planning training for people presenting with suicidal behaviour

Many people who have died or attempted suicide sought help from an emergency department (Kudo et al. 2010). However, in a 2015 review of care after a suicide attempt, patients and carers reported their emotional distress was not attended to, and many believed they were discharged too rapidly and were left to seek their own options for ongoing care (Black Dog Institute 2017).

Emergency departments experience constant, competing demands on clinicians' time and pose unique challenges in providing effective, compassionate care to people in a suicidal crisis. It can be challenging for clinical staff to address complex needs within strict organisational and legal boundaries, and short triage times can make building patient-clinician rapport difficult (Black Dog Institute 2017). Emergency department clinicians report a lack of confidence in assessing and managing suicide-related presentations (Jellinek et al. 2013).

To address this, some jurisdictions have already invested in standardised suicide risk mitigation and safety planning training for all emergency department clinicians. This training is improving quality, safety and clinical outcomes by ensuring that emergency department clinicians are skilled in using the same evidence-informed risk assessment approach and tool and in delivering compassionate care.

This training is even more important now because risk assessment has evolved from its original aim to predict future suicide. It is now referred to as suicide 'risk mitigation', which is approached as a compassionate, client-oriented yet systematic exploration of the client's current suicidal state and needs that informs a commensurate management care and co-created safety plan (Cole-King & Lepping 2010; Hawgood 2016; Hawgood & De Leo 2016).

16c: Support the alcohol and other drug workforce to undertake risk mitigation and safety planning training

“ I believe my partner could have been helped if there were more resources. He was put into emergency after a suicide attempt about three years before he died and they just let him go. Drugs and alcohol played a huge part in his and our lives and if he could have got more help maybe he would still be here. I wish he could have been helped. ”

41-year-old Western Australian woman whose partner died by suicide

There is a clear link between alcohol and other drugs and suicide. In 2017, 41.6 per cent of suicides in the 25–44-year age group involved drug and alcohol misuse disorders and acute intoxication (ABS 2018). There are several ways alcohol can increase suicidal behaviour, including as a central nervous system depressant and via increases in impulsiveness and psychological distress (Witt & Lubman 2018).

There are opportunities to identify and support people at risk of, or experiencing, suicidal behaviours and alcohol and drug misuse by referral to alcohol and drug services where appropriate, and by supporting this workforce to undertake contemporary risk mitigation and safety planning training. This support is likely to look different in each state and territory, reflecting different structures and workplace development programs.

16d: Better understand the suicide prevention activities of PHNs and support them to share best practice and innovation

In January 2019 the Commonwealth extended the funding for PHNs to 2021–22, with an additional \$77 million to commission suicide prevention interventions. PHNs have become a major funder of suicide prevention activities across Australia, which include helpline support, follow-up care for people who have attempted suicide, postvention bereavement services and workforce capability building.

With PHNs commissioning of suicide prevention interventions increasing rapidly, to aid joint service planning and commissioning it would be useful to better understand:

- the volume and type of activity, as well as who is receiving and delivering the services
- barriers and enablers faced by PHNs (such as lack of data for service planning and staff retention)
- who PHNs are collaborating with
- how PHNs are building their workforce capacity and how they could be better supported
- best practice and innovation.

PHNs have also indicated that an online platform to share learnings and best practice would be valuable, especially because the evidence is growing rapidly and the landscape often changing. Several PHNs have shown significant leadership and innovation in suicide prevention, and a platform to share this information is likely to accelerate progress and improve outcomes further.

Best practice spotlight

Joint regional mental health and suicide prevention planning

As an action within the Fifth Plan, PHNs and Local Hospital Networks are now required to undertake joint regional planning for integrated mental health and suicide prevention services and publish these plans by mid-2020.

Importantly, joint regional mental health and suicide prevention planning will:

- embed integration of mental health and suicide prevention services and pathways for people with or at risk of mental illness or suicide through a whole-of-system approach
- drive and inform evidence-informed service development to address identified gaps and deliver on regional priorities
- inform the coordinated commissioning of services across the stepped care spectrum of need for services and across the lifespan.

A best practice example of this is from the Brisbane North PHN, which, together with Metro North Hospital and Health Service, jointly developed *Planning for wellbeing – a joint regional plan for North Brisbane and Moreton Bay focusing on mental health, suicide prevention and alcohol and other drug treatment services*.

Informed by extensive consultation, *Planning for wellbeing* establishes the future directions for the region as a whole, not just the two sponsoring organisations. This regional focus has created challenges because organisations are usually more accustomed to organisational-level strategic or operational plans, where responsibility for implementation sits with just one organisation. *Planning for wellbeing* overcomes this, reflecting the learnings from extensive consultation and presents a commitment to shared objectives and actions over a five-year period.


16e: Consider the national peer workforce development guidelines, once completed, and any implications for the lived experience workforce

6 Just knowing that someone that you're talking to has gone through the same thing that you're going through at the time or have gone through and that you're not the only person – because that's the way you think, you're the only person in the world that feels that way. I've spoken to a lot of other people who have gone through different ups and downs and they say the same thing. Just knowing that there is a relationship out there and you've got the people that have gone through the same thing, you're not the only one suffering, that gave me a big sense of relief to know that it wasn't just me. Those people speak your language and it becomes even more and more real and more understandable. ”

Participant in the 2018 evaluation of the MATES in Construction workplace program

People with lived experience of suicidal behaviour who are ready and properly supported can play an important role in suicide prevention. This includes reducing stigma and discrimination by sharing their experiences, providing advice to funders on priority setting, program design and delivery, research and evaluation and delivering peer-supported or peer-led programs.

The evidence for peer-delivered programs is growing. Participants in the Peers for Valued Living program in the United States, a randomised controlled pilot study of a 12-week peer support program for people with elevated risk of suicide, reported highly positive experiences with peers' ability to relate, listen, advise and provide support during discussions about suicide, and overall increased connectedness and decreased hopelessness (Pfeiffer et al. 2018).



It is important that support is provided to further legitimise and grow the lived experience workforce. Roses in the Ocean, as the peak national body for people with lived experience of suicidal behaviour, has identified the following as important to achieving this:

- best practice guidance regarding how to authentically and effectively engage, work with and support people with lived experience of suicidal behaviour
- screening for readiness, training and ongoing support, and equitable employment conditions with peers in other sectors
- supporting integration into clinical environments through evidence of the benefits, clear role delineation, access to organisational supervision and peer support, and a supportive culture
- acknowledgement that some people prefer to volunteer their time, suggesting that a blended workforce of paid and volunteer peers is appropriate
- robust evaluations to strengthen the evidence base for effectiveness in Australia.

Within the Fifth Plan there is already a commitment to develop national peer workforce development guidelines. The National Mental Health Commission leads this work, which is due for completion in 2021.

17: Support suicide prevention competency throughout people's careers

17a: Work with universities across Australia to ensure there is high-quality suicide prevention content in undergraduate and postgraduate education

Clinicians indicate there is little to no suicide prevention content in undergraduate and postgraduate tertiary education in key disciplines such as medicine, nursing, midwifery, paramedicine and allied health.

There is an opportunity to work with universities to improve this, in the first instance focusing on the high-priority disciplines of medicine, psychology, psychiatry, nursing, midwifery, paramedicine, occupational therapy, speech pathology, social work, public health and health promotion and pharmacy. It is important that lived experience perspectives are included in updated curriculums.

The 2019 *Beyond the Emergency: a national study of ambulance responses to men's mental health* found that between 1 July 2014 and 30 June 2017, 15.3 per cent of ambulance presentations for males in the Australian Capital Territory, New South Wales, Northern Territory, Queensland, Tasmania and Victoria were for suicide ideation and 7.9 per cent were for suicide attempts.

Paramedics interviewed reported not having adequate education, skills and training to effectively work with suicidal people. Paramedics commented on the lack of mental health content in both university and in-service education courses.

“ I was taught to put restraints on, when sedation is required and how to do it but I guess teach me how to sit down and have a conversation with someone who is at their wits' end and you've just managed to take an electrical cord off around their neck. ”

Paramedic, male, aged 36 years¹⁸

¹⁸ Turning Point 2019, *Beyond the emergency: A national study of ambulance responses to men's mental health*, Turning Point, Richmond.

17b: Work with colleges and associations and state and territory ambulance services to strengthen suicide-related continuing professional development programs

Many of the professional colleges and associations formally accredit the training programs clinicians need to undertake to earn their annual continuing professional development points. The points are required to maintain their knowledge, competencies and registration. For paramedicine, state and territory ambulance services prescribe continuing professional development.

There are opportunities to work with the colleges and associations and state and territory ambulance services to encourage them to strengthen the content, quality and availability of accredited suicide prevention programs.

17c: Promote existing professional development opportunities

Two established professional development mechanisms have considerable reach across multiple disciplines that could potentially be better harnessed and promoted to increase suicide prevention competencies:

- The Mental Health Professional Online Development program is an evidence-informed online learning resource for people working in mental health, with content linked to the *National practice standards for the mental health workforce*. The program's suicide prevention content is limited and would benefit from a review and increased promotion.
- With a membership of 60,000 mental health clinicians, the Mental Health Professionals Network runs regular webinars on high-priority topics to support members' competencies. More than 2,700 clinicians attended a webinar on suicidal behaviours in school-aged children in February 2019, demonstrating high demand.

What positive change will making these areas of focus a priority achieve?

- Clinicians will be better supported throughout their careers to provide effective, compassionate care for people with suicidal behaviours.
- PHNs will be better supported to commission effective, integrated suicide prevention activities.
- The role people with lived experience of suicidal behaviour have in working with others to design and deliver suicide prevention activities will be legitimised and valued. Opportunities will be created to develop this important workforce.

Potential future priorities

- Extend suicide prevention curriculums into other tertiary courses such as drug and alcohol, family violence and teaching.
- Extend contemporary training in the collaborative assessment and care of people experiencing suicidal behaviours to community-based mental health clinicians and paramedics (as the next highest priority workforces in the health sector).
- Continue to strengthen joint planning between Local Hospital Networks and PHNs, including embedding co-commissioning models.

Rob's story

My journey of suicidal crisis was over a 25-year period. The main theme was my struggle with my sexuality knowing from a young age that I was gay. I was in environments that included a domestically violent home, bullying at school and moving into adulthood having a faith and being constantly told from the pulpit that my faith would not be valid if I did not adhere to the norms written down.

When I was in my early 20s, I fell ill with chronic fatigue syndrome. I was told from the pulpit that all my issues, both physical and mental, were the result of all the decisions I had made, and this was my punishment.

Life became very dark. It was compounded by the messages I received about my situation being all my fault and no manner of outside help was going to 'cure me'. What did not help was conversion therapy.

For many years I would search online for help, someone to talk to who would not think that I was evil. I had more failures than successes. I would find organisations online, but when I tried to contact them their emails would bounce back or I would not hear from them.

Over time, I finally thought I found some help – a counsellor that I connected with. However, the phone counsellor resigned. I was told I would be given another counsellor, but this never eventuated. Stops and starts made things more oppressive.

One thing that would be spoken about at our church pulpit was love and that the only love you can find is the love that a church environment can supply. For me that was not the case. The love that I did find was a LGBTQI community group that was run by Sharon Jones, who listened and treated me as a human being.

It took another two years or so to even become comfortable enough to share my most inner fears and suicidality. One weekend, I turned to Sharon and said I do not want to be here anymore. Sharon said she understood, and I finally felt that a lifetime of anguish and pain might have a chance of being sorted out. That conversation, those few words spoken to me by Sharon, started a three-year journey of being able to start to look at the pain and the hurt, and step by step, or even three steps forward one step back, move ahead.

I was able to get long-term counselling. My counsellor helped me to realise that what had been spoken into my life was not truth or love but fear. I went through stages of anger that I had been lied to and grief that my belief system was twisted. Slowly I felt a sense of freedom that I might be able to live a life that was true to who I was. I was able to rekindle my passion for singing. I started a Facebook page to share information about relevant topics and social events so that maybe I could help one person not to have to go through as dark an experience as I had.

The most loving, caring people can be the starting point of a person's healing journey. They are the ones who show unconditional love and compassion.

**Rob Tierney, a gay disabled man,
Tasmania**

Better use of data, information and evidence

Why is this a priority?

High-quality, timely data, information and evidence is important to suicide prevention efforts because it:

- improves our understanding of the prevalence of suicidal behaviour, especially among vulnerable groups
- informs what interventions and services are most needed, where and for whom
- informs which interventions are most likely to improve outcomes and be cost-effective
- facilitates real-time responses to elevated levels of suicidal behaviour within a local area
- allows suicide prevention efforts to be monitored and informs adjustments needed to maximise outcomes.

Figure 4 sets out the data and information needed to support any national suicide prevention efforts.



Figure 4: Information needs for effective suicide prevention

SURVEILLANCE DATA	EPIDEMIOLOGICAL DATA
INFORMATION NEED	
<ul style="list-style-type: none"> ▶ Identify escalated rates of suicide attempts and suicide in order to effectively communicate, coordinate and implement a localised service response if necessary ▶ Ensure information provided is accurate, timely and in context 	<ul style="list-style-type: none"> ▶ Prevalence of suicidal behaviour ▶ Risk factors, demographics, means and locations ▶ Health service utilisation ▶ Experiences of care ▶ Outcomes following care ▶ Contact with other service systems ▶ Targeting of investments and interventions ▶ Evaluation of investments ▶ Research
END USER	
<ul style="list-style-type: none"> ▶ Local communities and leaders ▶ Clinicians and service providers ▶ Government departments ▶ PHNs ▶ People delivering suicide prevention programs 	<ul style="list-style-type: none"> ▶ Local communities and leaders ▶ Clinicians and service providers ▶ Government departments ▶ PHNs ▶ Researchers ▶ Suicide prevention experts ▶ People delivering suicide prevention programs
DATA SOURCES	
<ul style="list-style-type: none"> ▶ PHNs ▶ Local service providers ▶ Police ▶ Ambulance ▶ State/Territory Coroners ▶ Helplines ▶ Local community data 	<ul style="list-style-type: none"> ▶ PHNs ▶ Non-admitted and admitted health service data ▶ Police ▶ Ambulance ▶ State/territory coroners ▶ National Coronial Information System, Australian Bureau of Statics and Australian Institute of Health and Welfare ▶ Program specific data ▶ Help lines ▶ Family violence ▶ Alcohol and other drugs
TIMELINESS	
<ul style="list-style-type: none"> ▶ Needed rapidly to inform the need for an immediate service response to prevent further harm 	<ul style="list-style-type: none"> ▶ Not needed as rapidly as not driven by an immediate need ▶ Detailed multi-factorial data analysis takes time ▶ Longitudinal data is important to reduce variations caused by small changes in numbers and for trend analysis
CORE ELEMENTS OF BEST PRACTICE INFORMATION SYSTEMS:	<ul style="list-style-type: none"> <u>Data linked within and between systems to drive decision making</u> <u>Good comparability</u> <u>Timely access to data for all who need it</u> <u>Transparent collection and use, with the right protections</u> <u>Data translated to information with meaning to end users</u> <u>Avoid contributing to stigma and discrimination</u> <u>Technology and informatics enabled</u>

What are the areas of focus?

18: Support suicide prevention research

The coordination of suicide prevention research to maximise its benefit, including rapid translation into practice, is essential to increasing our understanding about suicidal behaviour. Through this strategy, the following research areas are signposted as high priorities:

- understanding protective factors for suicide, including why they are protective, for whom and what universal interventions bolster these protective factors and address 'upstream' issues
- understanding health service use before and during suicide attempts and the experiences of the health system for people who have attempted suicide and their families and carers
- understanding assessment and treatment approaches for suicidal behaviour used in emergency departments around Australia and which approaches have led to better outcomes
- analysing primary care data to understand suicidal behaviours seen in primary care settings and care outcomes
- understanding effective models of post-crisis aftercare, including following people over time to better understand their service use and care outcomes
- identifying effective suicide prevention for high-priority populations
- identifying effective postvention bereavement services and models for those bereaved by suicide.

There also needs to be a stronger focus on piloting promising interventions, with evaluation results shared to inform potential scaling up or alternative investment. While there are examples of this occurring, there are also examples of where evaluations have not been commissioned, and of limited or no access to evaluation results.


To support suicide prevention research, there are benefits in establishing a central online repository to facilitate knowledge sharing on emerging evidence, in-progress research and research outcomes. It may be possible to utilise an existing online repository for health research in Australia.

19: Develop a new national system for collecting and coordinating information on suicide and self-harm, working with state and territory governments and data custodians to operationalise the system

Policymakers, funders, service providers and communities have a genuine and urgent need for accurate and timely data and information when there is a perceived increase in suicide attempts and suicides in localised areas. This is to ensure there is accurate, consistent information provided to all those who need it, including the community, and so that an appropriate, coordinated response can be implemented quickly to minimise further harm. The need for a nationally representative monitoring system for suicides and suicide attempts has been identified as a high priority.

In December 2018 the Commonwealth committed to develop a new national suicide and self-harm monitoring system, allocating \$15 million over three years. Work has already started between governments and data custodians to operationalise this new system.

As the new system takes shape across Australia, it will be important that the Commonwealth and states and territories work in partnership so that local service responses can be put in place to respond to any elevated rates of suicides and/or suicide attempts identified by the new system.



20: When a death occurs, maximise opportunities to use the data to ensure we learn from it

20a: Work with registry data custodians to consider establishing a suicide register in each jurisdiction, a national minimum dataset and increasing access to registry data by researchers

Victoria, Western Australia, Queensland and Tasmania have suicide registries and, together with the National Coronial Information System, these registries provide rich, accurate information that improves our understanding of suicidal behaviours, provides insights into how each person could have been better supported and identifies escalated rates of suicides and trends over time.

To ensure data from the various registers is comparable and reflects best practice, there is an opportunity to establish a national minimum dataset based on standard data items and definitions. Developing a national minimum dataset would also provide an opportunity to address existing data limitations such as Aboriginal and Torres Strait Islander identification and sexuality and gender identification.

Data from suicide registers underpins many of the major Australian studies of suicidal behaviours. The access protocols for each registry should be reviewed (as appropriate) to ensure they are in line with best access protocols.

20b: Consider routinely using data on people who have taken their own life in the community who have been receiving clinical mental health services so we can learn from their deaths

Some people who take their own life have been receiving clinical mental health services in the public health system. Even though most of these deaths occur in the community, a level of responsibility for the care of this person remains.

Understanding these deaths facilitates health services and clinicians examining how care could be provided differently in the future for better patient outcomes. In most jurisdictions data to underpin these examinations is connected. However, not all health departments, health services and clinicians regularly review this data to inform practice change.

20c: Consider the benefits of linked data to understand how people who took their own life sought help from the health system

Linked data is increasingly being used to understand the behaviours of people seeking help, including where they seek help and their pathways of care. There are opportunities in the suicide prevention sector to make greater use of linked data to accelerate our understanding of suicidal behaviours.

Linked data is starting to be used. Victoria has funded a study that links data from the Victorian Suicide Register with emergency department and hospital admissions data to understand each person's service use in the year prior to their death.

The insights from this project, and others like it, will build knowledge and technical capability in data linkage methodologies. Future national suicide prevention strategies are likely to have a priority action around the use of linked data.

21: Harness data to better understand suicidal behaviour and target investments

21a: Investigate how to improve data on suicide attempt presentations to emergency departments

Given the strong correlation between suicide attempts and suicide, suicide attempts are often considered a proxy for what is happening, or may happen, with suicide deaths. Collecting and publicly reporting on suicide attempts in Australia would, for the first time, establish a lead indicator for suicide.

However, data on emergency department presentations for suicide attempts is generally poorly recorded (Witt & Robinson 2019). Because data on intentional self-injury with or without intent to die is not coded separately in emergency department data systems, extracting this requires people with the right expertise to manually clean the data and construct algorithms to enable machine learning.

To facilitate public reporting, changes would first need to be made to the national minimum dataset on emergency department presentations and emergency department data collection systems across Australia. It is anticipated that public reporting would take a similar form to suicide death statistics – reported at the national and jurisdictional levels.

21b: Work with data custodians to consider regularly making localised data on suicidal behaviours available to better target investments

A key tenant of a systems-based approach is matching the mix of evidence-informed interventions to the needs of local communities. To support this, some states and territories have developed localised suicide prevention data audits in partnership with suicide registry data custodians, and under the Black Dog Institute's LifeSpan model for the Commonwealth-funded National Suicide Prevention Trial sites. These audits provide a comprehensive picture of suicide by region, including demographic characteristics, means, location and prior service use. They have been essential in understanding local characteristics and service needs so that programs can be commissioned accordingly.

A range of data sources, such as suicide registries, ambulance, police, alcohol and other drugs and the ABS' National Mortality Database, enable localised data.

21c: Investigate analysing data to understand suicidal behaviours seen in primary care settings

Many Australians seek help for suicidal behaviours in primary care settings, including from GPs, Aboriginal community-controlled health services, alcohol and other drug services, services funded by PHNs and via Medicare's Better Access initiative.

There is an opportunity to analyse primary care data to explore:

- Who seeks help? Are there common characteristics? Common risk factors?
- Where do they seek help? Over what period?
- For which suicidal behaviours do people seek help?
- What services do they receive?
- What are their care outcomes?

What positive change will making these areas of focus a priority achieve?

- We will know more than ever about suicidal behaviour and what is working to prevent and reduce it, as well as having reliable systems in place to inform interventions, understand changes overtime and track progress and outcomes.
- Research and evaluation will be targeted and coordinated around agreed priorities, with different forms of evidence valued, including lived experience.
- Access and use of existing data will be strengthened, as well as new data collected and reported to increase our understanding of suicidal behaviour.

Potential future priorities under this priority foundation

- Agree on a schedule of public reporting of key information from the suicide registers.
- Improve and expand the public reporting of suicide attempts by augmenting other datasets such as those from police and ambulance with emergency department data.
- Change emergency department data systems to also capture suicidal ideation.

Tim's story

I grew up in Melbourne and went to a private school for my secondary education. I then completed a university degree at La Trobe University. My first post-university job was as a trainee at ANZ bank. I have since worked in many large global organisations in relatively senior positions.

I have three children aged 24, 23 and 18. The youngest has Down syndrome. He is an absolute joy and makes me laugh. I was married for nearly 20 years. We bought a small farm just out of Albury. I love farming and it was a great upbringing for my kids.

However, in 2009 the wheels started falling off on what had been a great life to date. I was working as a divisional sales manager in a large corporate organisation when the global financial crisis started to impact our sales. I had to make many staff redundant. I felt enormous, constant pressure.

The signs and symptoms I experienced were:

- I lost 20+ kg in about eight weeks, despite maintaining my appetite.
- I couldn't sleep. I would go off to sleep but wake up within a few hours and lie awake all night despite trying to meditate, take vitamins, breathing exercises and more. I often felt myself shaking all over with nerves when awake at night. I was always totally exhausted.
- My stomach was churning a lot of the time and I had short bouts of chest pain.
- I was indecisive and overthinking when making decisions.
- I feel like there was nothing positive left in my life and was struggling to stay afloat.
- I was putting on a constant front to everyone.
- I felt ashamed as a father and husband that I was feeling this way.
- I had a short fuse/temper with those closest to me – my family. This I know was wrong, but I found it very difficult to control.

As a family one weekend, I floated horses for my kids to attend a gymkhana. When I got there, I could not face up to talking or socialising. Then at work, over a period

of a couple of months, tasks that were normally small became huge. For no reason, I felt like a fraud and that I would get found out. I felt I was often on the verge of wanting to cry. I felt I was valueless and a burden.

One day my ex-wife urgently booked me into see a psychiatrist. Despite the urgency, this took several weeks. The thought of seeing a psychiatrist made me very anxious but at the same time I hoped he could do something to make me feel better. The psychiatrist was brilliant. He quickly diagnosed that I was having a severe case of anxiety and depression. He was confident he could help improve and manage the situation. I felt an instant feeling of relief.

I was admitted into a Melbourne clinic for a few weeks. I continued to see my psychiatrist for several years. He was excellent in listening and in offering solutions to issues I raised. There were many ups and downs whilst we waited for the medications to have an effect. It took several trial and errors on different medications over a few months before he found the correct medications.

I did not go back to work for three to four months and spent the majority of my time at our farm. I felt and acted like a recluse. My ability to concentrate had severely been affected and my mind was ruminating constantly. I felt my family were not fully supporting me. Looking back, it would have helped enormously if family and close friends had researched anxiety and depression.

One day I got so low, I attempted to take my life. It was only thoughts about my children that stopped me. This was the lowest point I had ever reached.

Fortunately, I slowly improved and found my way back into the workforce. Socialising did not come back to me easily. Then, in 2011, I separated and divorced. This was a tough period.

2014 was a big year. I had some difficulties disclosing my mental health to my workplace. But sometimes in life, good things come from bad situations. I entered into my first same-sex relationship with my current husband.

In 2015 I decided to come out. It took enormous courage and strength to tell family and friends that I was gay. The majority have been extremely supportive. We were married in January 2019. I couldn't be happier.

Government leadership that drives structures and partnerships to deliver better outcomes

Why is this a priority?

With all governments recognising suicide prevention as a national priority, unprecedented funding and advances in the evidence base, Australia's suicide prevention sector has grown, and is growing, rapidly.

There are multiple funders, with the Commonwealth, state/territory governments and PHNs all investing in new infrastructure, programs and initiatives. There are also multiple non-government organisations, the private sector, research centres and service providers that provide advice, undertake research and deliver programs. Roles and responsibilities across the sector, especially between the funders, have never been agreed and articulated.

In this context, the report from the 2014 National Review of Mental Health Programs and Services noted a lack of coordination in suicide prevention programs and duplication between Commonwealth and state and territory efforts (National Mental Health Commission 2017). It is likely that this has led to missed opportunities to bring effective programs to scale, to co-invest in innovation and research and to openly share lessons learnt from pilots and trials to maximise outcomes.

Many people who work in suicide prevention comment that it can be difficult to understand the funding priorities of different governments, the areas of expertise and programs of peak organisations and research bodies, and what programs and activities are being implemented so they can connect and learn. It can be challenging to navigate, keep up and connect with people who are also trying to prevent suicide.


This priority foundation proposes new structures and partnerships to enable meaningful collaboration. This includes the opportunity to develop national best practice guidelines for suicide prevention in Australia. National best practice guidelines will assist policymakers, funders and commissioners, as well as organisations that deliver programs and provide care, to ensure what is being delivered is evidence-informed and maximises outcomes. National best practice guidelines would also promote minimum standards of care and improve consistency in suicide prevention programs across Australia.

What are the areas of focus?

22: Support national best practice guidelines for suicide prevention

An important foundation to increasing the effectiveness of Australia's suicide prevention system is to develop national best practice guidelines for suicide prevention. National best practice guidelines that encompass the full range of suicide prevention activities from prevention to support and treatment for people experiencing suicidal behaviour to postvention would have the following benefits:

- assist policymakers, funders and commissioners in ensuring they only fund safe, evidence-informed suicide prevention activities that align with international best practice and maximise outcomes for people
- ensure that people who have sought help for suicidal behaviours receive a consistent, evidence-informed minimum standard of care including in primary care, community mental health and hospital settings
- assist in building the competency of the workforce through a clear articulation of what constitutes best practice
- standardising evaluative data collection so there is consistency across programs in how to measure service and program activity, as well as primary and secondary outcomes. This will make comparisons across programs possible and evaluations more cost-effective.



National best practice guidelines would need to be developed by an organisation not involved in delivering suicide prevention interventions and potentially be endorsed by Health and Mental Health Ministers. The guidelines would link to and support the existing National Safety and Quality Health Service Standards and the Australian National Standards for Mental Health Services.

Given the evidence base for best practice in suicide prevention is growing rapidly, a process to ensure national guidelines are kept contemporary as a 'living document' will need to be agreed. This should also reflect any revisions to the National Safety and Quality Health Service Standards and the Australian National Standards for Mental Health Services.

23: Consider the structures needed to strengthen Australia's suicide prevention approach

23a: A dedicated strategic discussion on suicide prevention annually at a Health Council meeting

Health and Mental Health Ministers across Australia lead Australia's efforts to prevent suicide. The development of this strategy is a strong indication of their desire to work more closely to accelerate efforts.

A dedicated strategic discussion on suicide prevention at an annual meeting of Health and Mental Health Ministers would enable engagement on the progress of flagship initiatives, emerging evidence and promising results, and on future priorities, especially where there are opportunities to collaborate through joint planning and funding. For states and territories that have mental health ministers, ideally, they would also contribute to these strategic discussions.

23b: Strengthen engagement across the many sectors that have a role to play in preventing suicide

Health and Mental Health Ministers have a leadership role in bringing together their ministerial colleagues in other portfolios, such as justice, education, housing, child protection and family and domestic violence, to work alongside them to address suicide rates.

Within the Commonwealth and each state and territory, whole-of-government structures and approaches to suicide prevention are in place or are being developed. These structures and approaches differ across Australia and include regular strategic discussions at Cabinet level on suicide prevention, whole-of-government ministerial-level councils, whole-of-government frameworks or strategies and whole-of-government funding submissions.

Local governments have well-established connections with local communities and are increasingly funding and delivering suicide prevention programs. Local governments around Australia are also important partners in whole-of-government suicide prevention.

To continue maturing whole-of-government efforts, when this strategy concludes at the end of 2023, Australia's next suicide prevention strategy is proposed to have a whole-of-government focus and be endorsed by First Ministers.

NSW Premier's priority, strategic framework and whole-of-government governance

In October 2018 the NSW Government launched the whole-of-government *Strategic framework for suicide prevention 2018–23*. The framework brings together into a single coordinated effort all of the elements across the NSW Government and non-government system that are contributing to suicide prevention. This includes activity in education, communities, workplaces, justice, transport, planning and other sectors.

The framework has been supported with an unprecedented investment of \$87 million over three years to implement priority initiatives. The eight Towards Zero Suicides initiatives will deliver a new statewide system of suicide prevention services, supported by greater accessibility and integration of data and innovative approaches to implementation research. People with lived experience, government agencies and non-government organisations will be involved in co-designing the Towards Zero Suicides initiatives.

Overseeing the framework and implementation of the Towards Zero Suicides initiatives is the NSW Mental Health Taskforce, a senior executive group that consists of the NSW Ministry of Health, Department of Education, Department of Communities and Justice, Department of Customer Service, the Treasury, Department of Premier and Cabinet, and the NSW Mental Health Commission. This oversight is supported by the taskforce's Cross Agency Working Group on Mental Health.

Accelerating action in New South Wales, the Premier announced a new Towards Zero Suicides Premier's Priority in July 2019, with a goal to reduce the suicide rate in New South Wales by 20 per cent by 2023. The Premier's Priority brings even greater focus to the whole-of-government responsibility for suicide prevention and the contribution each government agency, service and sector can bring to reducing the suicide rate. Building on the framework and the Towards Zero Suicides investment, a delivery plan is being developed with input from a wide range of government agencies as well as people with lived experience and the non-government sector to address gaps in the current approach, promote greater linkage between systems and ensure people at risk of suicide or bereaved by suicide receive the help they need irrespective of where they may connect with a service.



24: Consider the benefits of a single suicide prevention digital gateway

To enable information sharing and connections across the suicide prevention sector, there are potential benefits of developing one suicide prevention digital gateway. This gateway could utilise existing infrastructure such as Life in Mind, Suicide Prevention Australia's Suicide Prevention Hub and the Centre for Best Practice in Aboriginal and Torres Strait Islander suicide prevention.

This gateway could play an important role in enabling information such as new research and evidence, guidelines, best practice programs and innovations to be captured in one gateway and be available to all. By providing one mechanism to share and connect, a gateway would build capacity, increase the effectiveness of investments and encourage best practice to be scaled.

What positive change will making these areas of focus a priority achieve?

- Health and Mental Health Ministers, and their departments, are enabled to work together to increase collective impact.
- Health and Mental Health Ministers are supported to lead and elevate Australia's suicide prevention efforts.
- Those who work in suicide prevention are better connected, with clearer roles and responsibilities.

Potential future priorities under this priority foundation

- Develop a whole-of-government national suicide prevention strategy for Australia for First Ministers to endorse. This would align with the key directions in Australia's next national mental health and suicide prevention plan (the sixth plan).

Appendix 1:

Existing strategies and frameworks

Commonwealth

Life: Living is for everyone

<https://www.healthdirect.gov.au/partners/life-living-is-for-everyone>

Australian Capital Territory

ACT Government's Office for Mental Health and Wellbeing work plan 2019–21

<https://www.health.act.gov.au/about-our-health-system/office-mental-health-and-wellbeing>

New South Wales

Strategic framework for suicide prevention in NSW 2018–2023

<https://www.health.nsw.gov.au/mentalhealth/Pages/suicide-prevention-strategic-framework.aspx>

Northern Territory

Northern Territory suicide prevention strategic framework 2018–2023

<https://health.nt.gov.au/health-governance/suicide-prevention-strategy-review>

Queensland

Queensland suicide prevention action plan 2015–2017

<https://www.qmhc.qld.gov.au/strategic-planning/action-plans/suicide-prevention>

South Australia

South Australian suicide prevention plan 2017–2021

<https://www.sahealth.sa.gov.au/wps/wcm/connect/Public+Content/SA+Health+Internet/Health+services/Mental+health+services/Suicide+Prevention+Plan+Feed+back>

Tasmania

Tasmania suicide prevention strategy 2016–2020

https://www.dhhs.tas.gov.au/mentalhealth/suicide_risk_and_prevention/new_suicide_prevention_strategies

Victoria

Victorian suicide prevention framework 2016–2025

<https://www2.health.vic.gov.au/about/publications/policiesandguidelines/victorian-suicide-prevention-framework-2016-2025>

Western Australia

Suicide prevention 2020: Together we can save lives

<https://www.mhc.wa.gov.au/about-us/strategic-direction/suicide-prevention-2020-together-we-can-save-lives/>



Appendix 2: Membership of the National Suicide Prevention Project Reference Group

Chair – Dr Margaret Grigg, (former) Executive Director, Health Service Policy and Commissioning, Victorian Department of Health and Human Services (May 2018 – August 2019)

Chair – Matthew Hercus, Director, Mental Health Branch, Victorian Department of Health and Human Services (September 2019 – April 2020)

Lucy Brogden, Chair, National Mental Health Commission

Joe Calleja, Suicide Prevention Australia – Lived Experience Network

Adj/Associate Professor Chris Carter, CEO, North Western Melbourne Primary Health Network

Professor Helen Christensen, Director and Chief Scientist, Black Dog Institute

Bronwen Edwards, CEO and Founder, Roses in the Ocean

Russell Evans, A/Program Manager, Suicide Prevention, Queensland Mental Health Commission

Parker Forbes, Suicide Prevention Australia – Lived Experience Network

Ros Garrity, LifeSpan Implementation Manager, Health Policy and Strategy, ACT Health

Dr Aaron Groves, Chief Psychiatrist, Mental Health, Alcohol and Drug Directorate, Tasmanian Department of Health and Human Services

Jacinta Hawgood, Senior Lecturer, Australian Institute for Suicide Research and Prevention

Dr Peter Jenkins, Board Member, Royal Australian and New Zealand College of Psychiatrists

Dr Claire Jones, Director, Mental Health, South West Sydney Local Health District, Liverpool Mental Health Centre

Tim Keane, Suicide Prevention Coordinator, Mental Health, Alcohol and Other Drugs Branch, Health Policy and Strategy Division, Northern Territory Department of Health

Janet Martin, Director, Clinical Governance, Office of the Chief Psychiatrist, Mental Health Alcohol and Other Drugs Branch, Queensland Department of Health

Nieves Murray, CEO, Suicide Prevention Australia

Professor Jane Pirkis, Director of the Centre for Mental Health, Melbourne School of Population and Global Health

Associate Professor Morton Rawlin AM, Vice President, The Royal Australian College of General Practitioners

Mark Roddam, First Assistant Secretary, Mental Health Division, Commonwealth Department of Health

Sam Rosevear, General Manager, Strategy and Policy, Beyond Blue

Jaelea Skehan, Director, Everymind

Dave Thompson, Acting Principal Project Officer – Suicide Prevention, Office of the Chief Psychiatrist, South Australian Department for Health and Wellbeing

Stephen Scott, Principal Policy Officer, Social Policy, Mental Health Branch, NSW Ministry of Health

Advice was also provided by The National Suicide Prevention Adviser, Ms Christine Morgan and the National Suicide Prevention Taskforce, Orygen: The National Centre for Excellence in Youth Mental Health, Turning Point, R U OK?, On the Line, Lifeline and the Australian Psychological Society.

Advice was also provided by the following Indigenous suicide prevention experts:

Professor Tom Calma AO, Co-Chair, Reconciliation Australia

Professor Pat Dudgeon, School of Indigenous Studies, University of Western Australia

Dr Vanessa Lee, Senior Lecturer, The University of Sydney

Tom Brideson, Deputy Commissioner, Mental Health Commission of New South Wales

Strategy written by Jane Blurton, Project Lead, Victorian Department of Health and Human Services

Glossary

Cultural safety: Identifies that health consumers are safest where health professionals have considered power relations, cultural differences and patient rights. Culturally safe services are respectful, inclusive and enable specific populations and communities to participate in decision making. Most importantly cultural safety is defined by the experience of the consumer, not the health professional.

Deliberate or intentional self-harm: Self-poisoning and self-injury for which there may be suicidal intent, no suicidal intent, or mixed motivations. Each instance of self-harm may have a different motivation, even within one individual. While some instances of self-harm are characterised by suicidal thinking, self-harm is often not an attempt at suicide; in some instances, young people engage in self-harm rather than ending their life (Klonsky 2007).

Discrimination: Unfair treatment of a person or group of people on the basis of a particular characteristic.

Early intervention: The early identification of risk factors and provision of timely treatment, care or support for people experiencing early signs and symptoms of mental illness. It aims to prevent the incidence, severity and impact of mental illness.

Gayaa Dhuwi (Proud Spirit) Declaration: A declaration on Aboriginal and Torres Strait Islander leadership across all parts of the Australian mental health system to achieve the highest attainable standard of mental health and suicide prevention outcomes for Aboriginal and Torres Strait Islander people.

Lived experience: Individuals with a lived experience of suicide are those who have experienced suicidal thoughts, survived a suicide attempt, cared for someone who has attempted suicide, been bereaved by suicide, or been touched by suicide in another way.

Local Hospital Networks (LHNs): Entities established by state and territory governments to manage single or small groups of public hospital services, including managing budgets and being directly responsible for performance. Most, but not all, LHNs are responsible for managing public hospital services in a defined geographical area. At the discretion of states and territories, LHNs may also manage other health services such as community-based health services. LHNs may have different names in some jurisdictions. For example, they are referred to as Local Health Districts in New South Wales, Health and Hospital Services in Queensland, Local Health Services in South Australia, and the Tasmanian Health Service in Tasmania.


Mental health and wellbeing: The World Health Organization defines mental health and wellbeing as a state of wellbeing in which every person realises their own potential, can cope with the normal stresses of life, can work productively and fruitfully and is able to make a contribution to their community.

Mental health problem: Diminished cognitive, emotional or social abilities but not to the extent that the diagnostic criteria for a mental illness are met.

Mental illness: A clinically diagnosable disorder that significantly interferes with a person's cognitive, emotional or social abilities. Examples include anxiety disorders, depression, bipolar disorder, eating disorders and schizophrenia.

Non-suicidal self-injury: A proposed DSM-5 diagnosis referring to deliberate injuring of oneself without suicidal intent, and does not include self-poisoning. The most common form is self-cutting, but other forms include burning, scratching, hitting, intentionally preventing wounds from healing, and other similar behaviours.

Person-led: Treatment, care and support that places the person at the centre of their own care and considers the needs of the person's carers.



Postvention: Suicide prevention activities that provide support for people affected by suicide. These activities are essential in coping with suicide loss and reducing further suicides and may include peer support, employee assistance programs, bereavement services and counselling.

Primary care: Generally the first point of contact for people living with mental health problems or mental illness and their carers. Primary care providers include general practitioners, nurses, allied health professionals, pharmacists and Aboriginal and Torres Strait Islander health workers.

Primary Health Networks (PHNs): Entities contracted by the Commonwealth to increase the efficiency and effectiveness of medical services for patients, particularly those at risk of poor health outcomes, and improving coordination of care to ensure patients receive the right care in the right place at the right time. There are 31 PHNs in Australia.

Social and cultural determinants of health: All the factors (social, environmental, cultural and physical) different populations are born into, grow up with and function with across the lifespan that potentially have a measurable impact on the health of human populations.

Social and emotional wellbeing: The Aboriginal and Torres Strait Islander view of health. This view is holistic and includes mental health and other factors such as the social, spiritual and cultural wellbeing of people and the broader community.

Stepped care: An evidence-based, staged system comprising a hierarchy of interventions, from the least to the most intensive, matched to a person's needs. Within a stepped-care approach, a person is supported to transition up to higher intensity services or to transition down to lower intensity services as their needs change.

Stigma: A negative opinion or judgement that excludes, rejects, shames or devalues a person or group of people based on a particular characteristic. Stigma may include self-stigma, social stigma and structural stigma.

Suicidal behaviour: An umbrella term that encompasses the full range of behaviours related to suicide including thinking about suicide (ideation), planning for suicide, attempting suicide and suicide itself.

Suicidal ideation: Thinking about, considering or planning for suicide. Ideation can range from fleeting thoughts to detailed planning.

Suicide: A death resulting from an intentional self-inflicted act.

Suicide attempt: A deliberate self-destructive act where there is a clear expectation of death.


Suicide prevention: The umbrella term for the collective efforts of governments, community organisations, mental health practitioners, related professionals, individuals, families and communities to prevent, intervene early and provide help for suicidal behaviour with the aim of reducing the incidence of suicide.

Suicide prevention community connector: People who have face-to-face contact with large numbers of community members as part of their usual routine. They may be trained to identify people at risk of suicide and refer them to treatment or supporting services as appropriate. This can also be referred to as a community gatekeeper.

Whole-of-government approach: Recognises the complex nature of suicide and draws expertise from, coordinates between and collaborates with a variety of disciplines, professions and perspectives to address suicide in a holistic and collective way. Sometimes referred to as a cross-sector approach.

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