

An evidence-based systems approach to suicide prevention: guidance on planning, commissioning and monitoring



Document for
Primary Health Networks

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Executive summary

Suicide is a significant public health issue in Australia, posing a considerable burden of disease and mortality.

Primary Health Networks (PHNs) are in an ideal position to improve suicide rates by virtue of their links to hospitals, general practice, health care, NGOs, and the communities which they serve. However, they may not have knowledge of the best evidence-based strategies which will lead to a reduction in suicide rates.

This resource is designed to provide guidance about the strategies that have been found in previous high quality research to reduce suicide rates and attempts. The *systems approach* to suicide prevention offers information about nine strategies that, when implemented within a specific community at the same time, are likely to lead to suicide reduction.

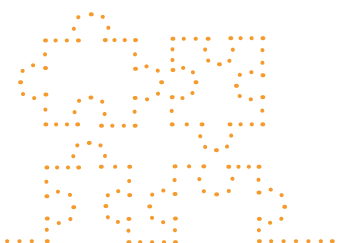
The guidance contained within this document is designed to provide PHNs with information to help commission and evaluate suicide prevention services. The nine evidence-based strategies include:

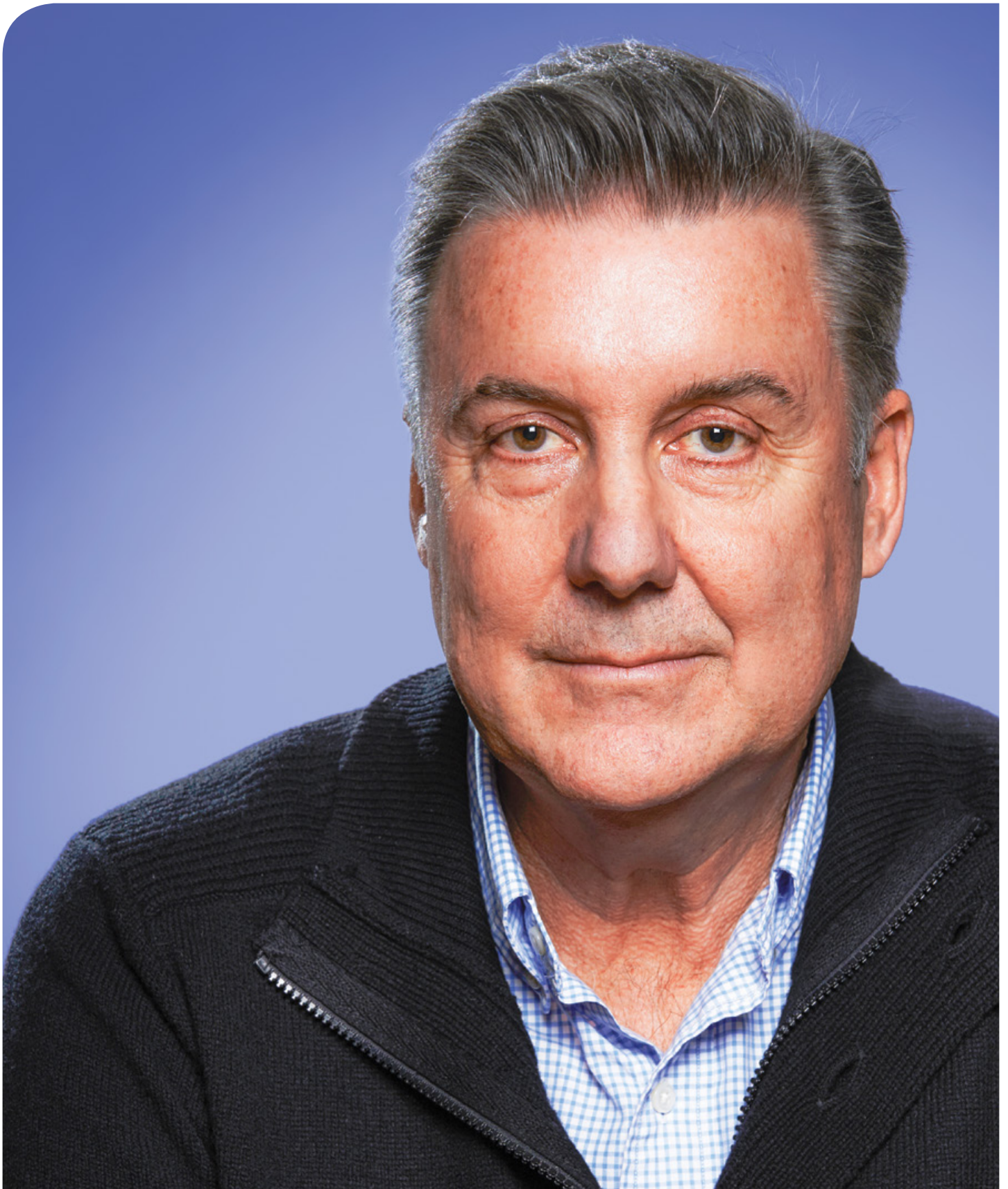
- **Aftercare and crisis care (strategy one)** – A suicide attempt is the strongest risk factor for subsequent suicide. To reduce the risk of a repeat attempt, a coordinated approach to improving the care of people after a suicide attempt is outlined. PHNs are encouraged to draw on their links with hospital and health services to establish local suicide prevention and crisis teams, develop resource packs, and ensure patients are followed up.
- **Psychosocial and pharmacotherapy treatments (strategy two)** – Mental illness is associated with a large portion of suicide attempts. Providing accessible and appropriate mental health care is essential to suicide prevention. The two main therapeutic options that have been found to reduce suicidal thoughts and behaviours are psychosocial treatment (such as cognitive behaviour therapy) and pharmacotherapy (using pharmaceutical drugs to treat mental illness and associated symptoms). PHNs are encouraged to assist in improving the mental health care of at-risk individuals whilst working within the confines of the public health system. This may involve partnering with relevant organisations to develop or disseminate treatment guidelines and new approaches to screening for mental illness and/or symptoms.
- **GP capacity building and support (strategy three)** – Primary care clinician education is one of the most promising interventions for reducing suicide. Suicidal individuals visit primary care providers in the weeks or days before suicide. In Australia, GPs are the most frequently reported providers of mental health care. PHNs are encouraged to identify, commission, and promote GP education based on provided criteria.
- **Frontline staff and gatekeeper training (strategies four and five)** – Gatekeepers (those who come into contact with at-risk individuals) may influence a suicidal person's decision to access care. Gatekeeper programs focus on increasing mental health literacy and teaching skills to assess, manage, and provide resources for at-risk individuals. PHNs are encouraged to identify potential gatekeepers across the community, as well as source and promote gatekeeper training where appropriate.
- **School programs (strategy six)** – Schools provide a cost-effective and convenient way of reaching young people. School-based programs are often focused on increasing help-seeking, mental health literacy, and knowledge of suicide warning signs and help strategies. PHNs may wish to partner with schools to encourage the adoption of evidence-based programs within national social and emotional wellbeing frameworks.
- **Community campaigns (strategy seven)** – These are best delivered in conjunction with other strategies and may improve mental health literacy in the general population. PHNs are encouraged to work closely with local communities and government organisations to identify existing programs and ensure targeted, consistent messaging.
- **Media guidelines (strategy eight)** – Suicidal behaviour can be learned from the media. Media guidelines recommending the responsible reporting of suicide by the media can reduce suicide rates. PHNs are encouraged to work with local media to promote and utilise the Mindframe media reporting guidelines.
- **Means restriction (strategy nine)** – Restricting access to the means of suicide is considered to be one of the most effective suicide prevention strategies. PHNs are encouraged to draw on partnerships with government and community organisations in order to analyse data on suicide deaths. Data may reveal suicide 'hot spots' and means restriction will then be tailored to these areas and means.

The systems approach is a community wide approach with strong collaborations needed across many sectors within a community. In order to facilitate community engagement processes, guidance on how to engage with the community at large, including with Aboriginal and Torres Strait Islander communities, is provided within this document. Recommendations for community engagement includes assessing the change readiness of a community, building community capacity and strengths, utilising existing suicide prevention networks, incorporating lived experience, and using appropriate language. When working with Aboriginal and Torres Strait Islander populations it is imperative to consider cultural competence and cultural safety, and account for cultural difference between general population and Aboriginal and Torres Strait Islander suicide prevention activities.

The systems approach requires monitoring and evaluation to provide feedback on effective strategies. Measuring changes in suicide deaths and attempts is at the forefront of the evaluation strategy. Data for suicide deaths and attempts can be obtained from many sources and a table of relevant data sources is included. Secondary outcome measures will provide further information on the efficacy of the individual strategies and a list of potential measures is provided. The implementation of standardised measures is recommended and a list of freely available questionnaires is included within this document.

Suicide is a human problem. It places substantial burden on individuals, families, communities, and the nation in terms of emotional suffering as well as economic and productivity losses. This resource will help PHNs to guide the implementation of evidence-based strategies that may help to reduce the suicide rate and relieve the human suffering caused by suicide in their regions.





“For me, the feeling from losing my brother from suicide continues to be a cold, dark place. Hope (and warmth) comes from having the conversation with others about suicide prevention and checking in with the human spirit. Also, I am heartened by the fact that there is now evidence available to support a new approach to suicide prevention which is planned to be implemented into our communities – very shortly.” – DAVID HALES, VOLUNTEER PRESENTER, BLACK DOG INSTITUTE

Planning and commissioning a systems approach to suicide prevention

Preamble

Suicide rates in Australia have not declined over the past decade, with recent statistics showing they may actually be rising.¹ To date, suicide prevention efforts have been fragmented in terms of both geography and funding, however, the significance of the problem demands a new approach.

A systems approach to suicide prevention, whereby multiple evidence-based strategies are implemented simultaneously within a localised area, offers a strong empirical framework to improve services and their integration. Using a systems based approach, estimates suggest it may be possible to prevent 21% of suicide deaths, and 30% of suicide attempts.^{2,3} This will, in turn, save the Australian economy billions of dollars per year.⁴

Intended audience for this document

The resource provides PHNs with the guidance that will help them commission suicide prevention services using an evidence-based framework, while recognising the diverse population sub-groups found within PHN regions.

The document is intended for use by individuals employed within PHNs, including those employed in areas such as Integrated Care, Population Health, Aboriginal and Torres Strait Islander Health, and Planning, Engagement, and Strategy.

This document aims to provide readers with:

- The evidence base for the systems approach to suicide prevention
- Guidance for implementing the nine evidence-based strategies at a local level
- Guidance for tailoring each strategy to meet the needs of populations and communities at higher risk of suicide, such as those in rural and remote areas, Aboriginal and Torres Strait Islander, LGBTI (lesbian, gay, bisexual, transgender, and intersex), and clients of alcohol and other drugs services

- Guiding principles for involving those from a lived experience perspective of suicide in the implementation strategy
- Guidance for engaging with the community
- Guidance on measuring the effects of the systems approach within a local region
- A list of resources and references.

Development process

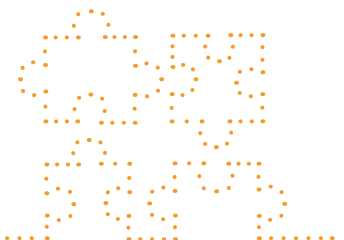
This resource was developed in conjunction with PHNs, community representatives, and people from a lived experience perspective. Consultations were conducted with PHNs from urban, rural, and remote settings. An Expert Working Group including key members from relevant organisations provided guidance and direction on the creation of this document. Input from key stakeholders including from Aboriginal and Torres Strait Islander peoples, LGBTI, and alcohol and other drugs service representatives also provided advice and feedback on tailoring the strategies for high-risk communities.

Reader note

The definition of 'suicide death' and 'suicide attempt' used within this resource is aligned with those used by the World Health Organisation:⁵

- Suicide – the act of deliberately killing oneself
- Suicide attempt – any non-fatal suicidal behaviour, and refers to intentional self-inflicted poisoning, injury, or self-harm which may or may not have a fatal intent or outcome.^a

^a Whilst recent definitions of suicide attempt are associated with at least some intent to die,⁶ it should be noted that intent to die may be difficult to determine from available datasets. Most agencies code suicide attempts as 'intentional self-harm' (according to the International Classification of Diseases 10th Revision⁷). This makes it difficult to determine the proportion of self-harm cases where intent was present.



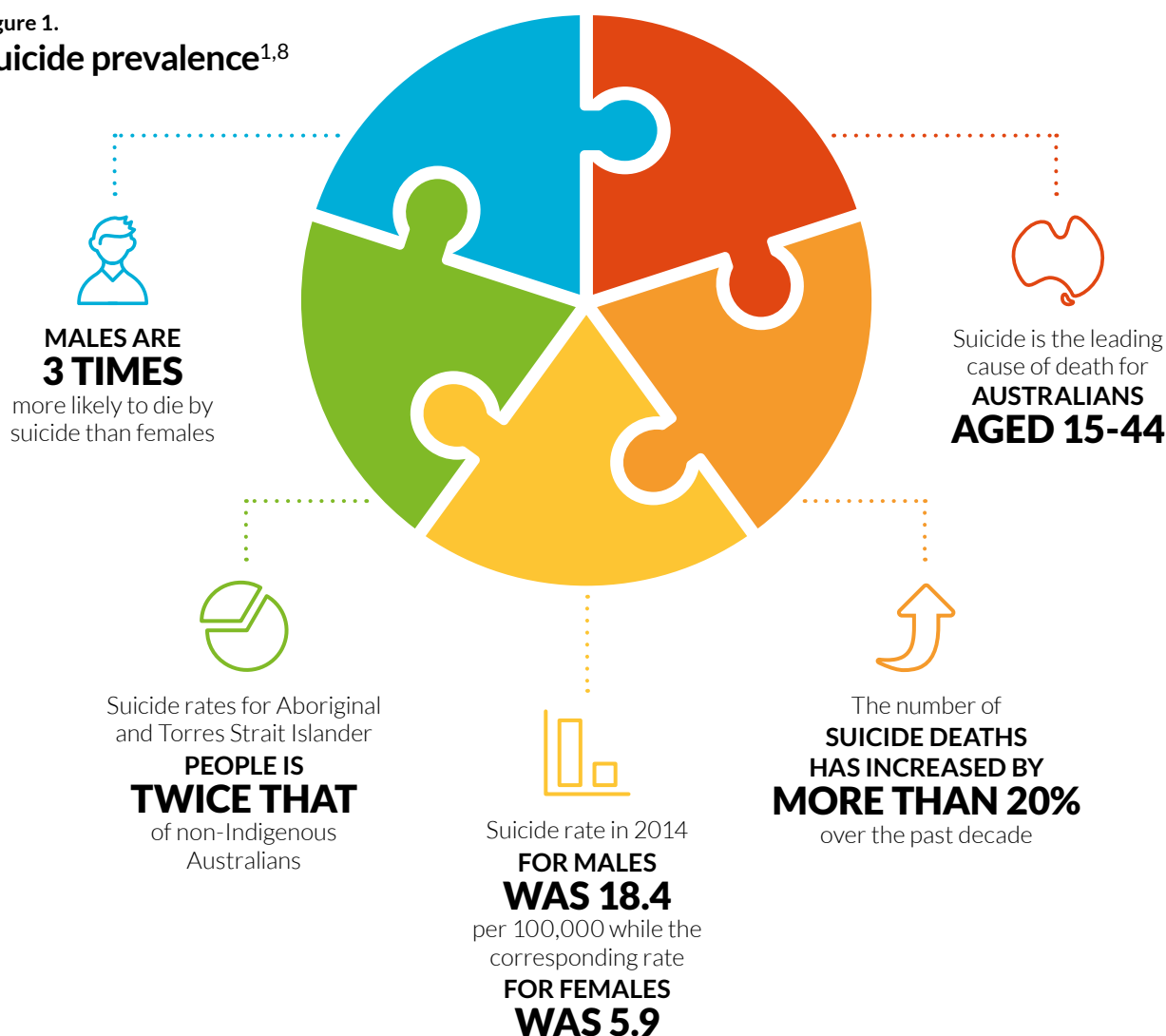
Section 1 – Background

Suicide in Australia

In 2014, 2,864 Australians died by suicide.¹ Between 2013 and 2014 the suicide rate increased from 10.9 per 100,000 to 12.0 per 100,000.^{1,8} For every suicide death, as many as 25 individuals will attempt suicide.^{9,10} Based on this estimate, approximately 71,600 people in Australia will attempt suicide in any given year.

The suicide rate may be higher for some communities. For example, the LGBTI community have a lifetime prevalence of suicide attempts that is up to three times higher than the general population.^{11,12}

Figure 1.
Suicide prevalence^{1,8}





Developing an integrated approach to preventing suicide

Suicide is a significant issue globally⁵ and understanding of effective suicide prevention interventions has expanded considerably in the past few years.

Strong evidence from overseas points to the benefits of combining effective strategies into a multilevel and multifactorial approach. Referred to as the 'systems approach', this involves evidence-based interventions from population level to the individual, implemented simultaneously within a localised region. Multiple strategies implemented at the same time are likely to generate bigger effects than just the sum of individual parts due to synergistic effects.

Integral to the success of this program is collaboration between local healthcare, community services, and those with lived experience. This encourages local ownership of activities and builds capacity for community members to have an active role in the planning, development, implementation, and maintenance of these activities.

To be successful, services must provide inclusive care for all people in the community, taking into account their gender, sexuality, ethnicity, Indigenous status, history of trauma, and other factors that impact on how a person will seek assistance.

Suicide prevention strategies

Nine evidence-based strategies have been included in the Australian systems approach model (Figure 2).

These strategies cover the spectrum of interventions for high-risk individuals (see Appendix A for a list of risk factors) through to universal population level

interventions. Whilst some strategies may be more effective than others in different locations, simultaneous implementation is key to the success of the model.

A comprehensive overview of how PHNs can implement each strategy is contained in Section 2 of this document.

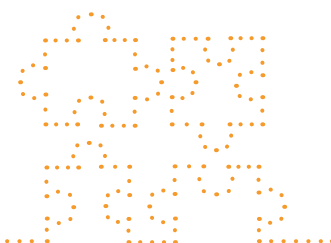


Figure 2.

The nine evidence-based strategies

Ideally, all strategies should be implemented within a systems approach model, although implementation may vary across communities according to needs.



Role of PHNs in suicide prevention

Currently, the remit of PHNs in suicide prevention is limited to commissioning health services and primary care. However, in recognition that a systems approach to suicide prevention extends beyond the delivery of health and medical services, guidance is provided about engagement with government and community groups

responsible for broader aspects of suicide prevention. These include groups who provide services under commonwealth and state government departments, such as family and community services, police and justice, education and NGOs. The role of local councils is also considered.

Scope of PHN role

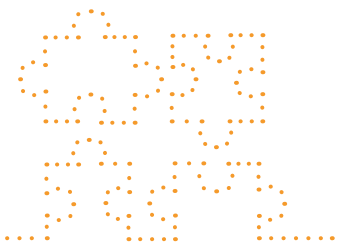
The successful implementation of suicide prevention activities will be contingent on sourcing, selecting, and commissioning appropriate services.

Not all suicide prevention activities fall in the remit of the PHN. However, PHNs may influence change locally through the actions contained in the local suicide prevention action plan developed by the PHN (see Box 1). All nine strategies for preventing suicide will involve local consultation and collaboration.

Box 1.

The local prevention action plan includes:

- Collaboration to deliver improved care through efforts to share information between agencies and develop joint strategies
- A survey or audit of current workforce capacity and training as recommended within many of the nine strategies
- A survey of local service providers to explore the use and dissemination of evidence based therapies and activities
- A workshop to promote recommended therapies and activities, and to develop a shared care planning process
- A survey of diversity strategies and their implementation, including LGBTI training; cultural competency to work with culturally and linguistically diverse people; and Aboriginal and Torres Strait Islander people and communities
- The development of care protocols and shared practice guides with local providers.



Prioritising strategies

Prior to commissioning any services, a thorough audit of existing suicide prevention activities and related services within the area is recommended. PHNs may find that some of these services are already operational in their communities and require only slight modifications to align them with the evidence, using the guidance in this document. Those PHNs who already have particular services and strategies implemented within their communities can focus on strategies and services that are yet to be implemented.

Other PHNs may have only a few strategies implemented and may wish to prioritise the strategies they focus on first. In these cases, PHNs may focus on implementing the strategies that are predicted to have the greatest impact in the first instance, followed by

resource allocation and implementation of the remaining strategies. The assumption is that the more strategies a PHN region implements, the greater the impact.

Predictions of impact have been calculated by researchers at the NHMRC Centre of Research Excellence in Suicide Prevention¹³ and are shown in Figures 3 and 4.

Strategies predicted to have the most impact are:

- Strategy one – Aftercare and crisis care
- Strategy two – Psychosocial treatment
- Strategy three – GP capacity building and support
- Strategy five – Gatekeeper training
- Strategy nine – Means restriction

Figure 3.

Estimated reduction in *suicide attempts* for certain strategies

*Priority strategies for reducing suicide attempts.

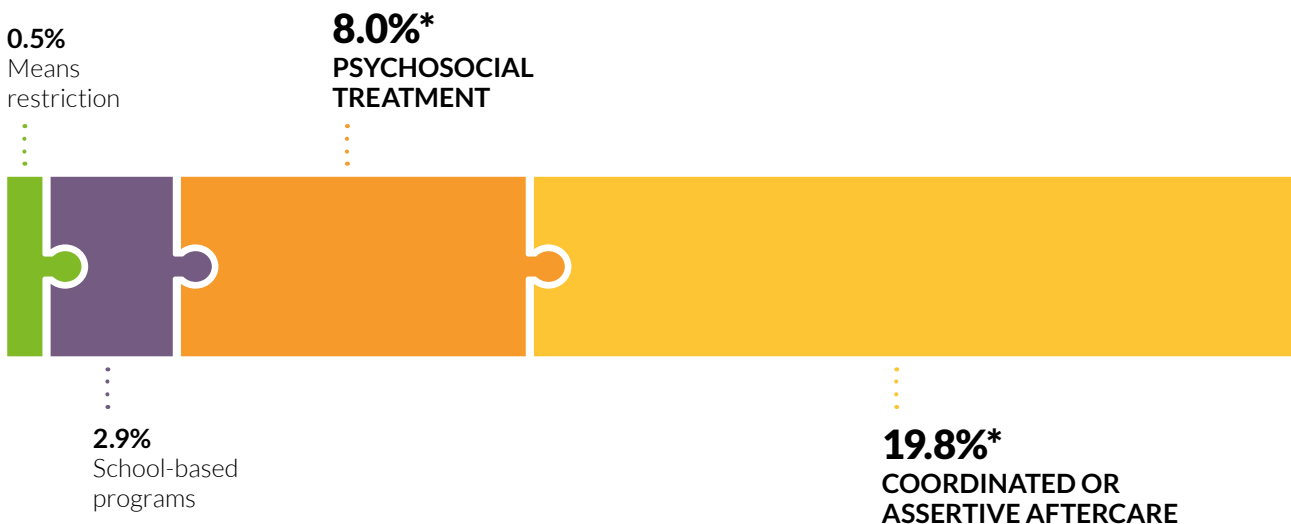
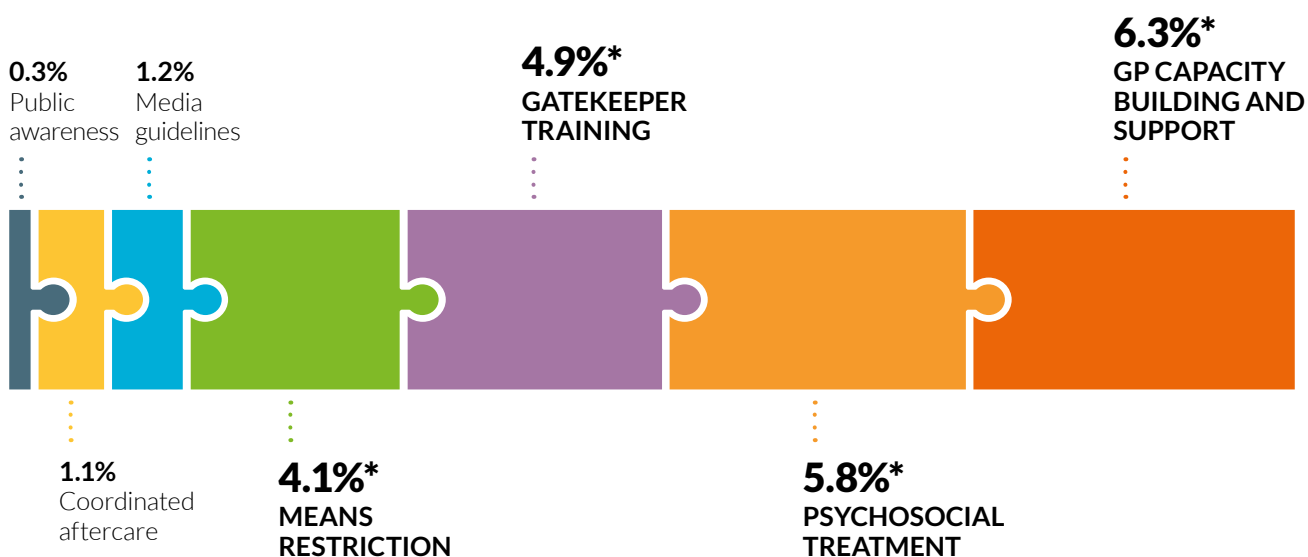


Figure 4.

Estimated reduction in *suicide deaths* for certain strategies

*Priority strategies for reducing suicide deaths.



Other considerations

During their needs assessment and planning processes PHNs may wish to consider the following three elements, which will increase the likelihood of successful implementation.¹⁴ Note that these elements are not necessarily sequential as some components may be completed simultaneously.

1. The collection of data about local suicides (a **suicide audit**) from coroners, hospitals, and health records in order to build an understanding of local factors that precipitate suicide, such as high-risk demographic groups. Good quality outcome statistics are critical to informing suicide prevention priorities and for evaluating the impact of implemented prevention strategies.
2. The establishment of a **multi-agency suicide prevention group** involving key statutory agencies whose support is required to effectively implement the plan throughout the local community and provide leadership. The group may include members from medical, health, and community organisations,

as well as individuals with lived experience.

The inclusion of Clinical Councils, Aboriginal Health Councils (see Section 3), Community Advisory Groups, or other such groups may be particularly relevant during this phase.

3. The development of a **suicide prevention action plan** which sets out the specific actions that will be taken to reduce suicide risk in the local community. This plan will consist of a set of core principles that each community will adhere to, based on best evidence, but tailored to unique community needs. Aboriginal and Torres Strait Islander communities should be placed in the 'driver's seat' in the development of the plan which will include culturally-informed elements. Presentation of literature and information that is in the language and degree of sophistication and/or simplicity appropriate to the community is essential.



“We have the knowledge to save thousands of lives and to significantly improve the lives of those in distress through the systems approach to suicide prevention. In many cases these strategies are already being used individually. What is unique about this approach is that it involves the simultaneous implementation of nine strategies within a community setting.”

— SCIENTIA PROFESSOR HELEN CHRISTENSEN, CHIEF SCIENTIST AND DIRECTOR, BLACK DOG INSTITUTE

Section 2 – Recommendations for implementing the systems approach within PHNs

Strategy one: Aftercare and crisis care

A suicide attempt is the strongest risk factor for subsequent suicide, with the risk of repetition remaining high up to 12 months after an attempt.¹⁵ As such, improving the care received by people after a suicide attempt is important for reducing suicide attempts and deaths. Two main approaches to reduce the risk of a subsequent attempt are brief contact interventions and coordinated, assertive aftercare. The latter approach is also known as continuity of care models.

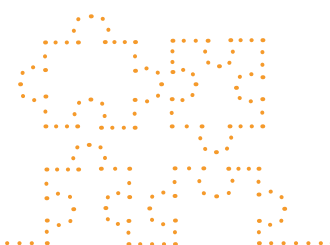
Brief contact interventions consist of time limited contact with those discharged after presentation to an emergency department or admission to hospital for intentional self-harm. Contact can take the form of a postcard, letter, or phone call. Brief contact interventions are effective in reducing suicidal behaviour including intentional self-harm and repeated attempts.¹⁶

Continuity of care models, such as the Baerum and Norwegian models,^{17,18} seek to improve the quality and continuity of care following a suicide attempt. These models maintain long-term care through the implementation of a systematic 'chain of care' that links general hospitals and community aftercare services with patients discharged following a suicide attempt. Rapid follow up is performed by a dedicated team or individual who is responsible for coordinating the patient's care.

Part of patient care may include referral to crisis lines (such as Lifeline, Kids Helpline, Suicide Call Back Service) or eHealth interventions to increase access and engagement to care. Crisis lines reduce crisis states and hopelessness in callers during the course of a telephone session.¹⁹ Increased promotion of crisis lines increases uptake.²⁰ Several eHealth programs are available that impact modifiable risk factors for suicide including depression, anxiety, psychological pain, and hopelessness. These may be particularly helpful for individuals in rural and remote areas where access to face-to-face services may be limited.

Recommendations

- **Establish collaborative partnerships with local hospital networks, services, or health districts** – This will help to ascertain which of the below services are already operational and encourage hospital services to adopt aftercare recommendations.
- **Establish local Suicide Prevention Teams** – Team members may include liaison psychiatrists, Aboriginal health and mental health workers, social workers, psychologists, and district community health nurses. It is important to tailor team membership in line with local need and local community constituents. PHNs may wish to ask their Suicide Prevention Teams to conduct psychosocial assessments of each patient who has had a suicide attempt, and this should include managing emotional distress. PHNs may also wish to commission services to partner with the Suicide Prevention Team and other key members to create a 'Suicide Attempt Quality in Care Guide' detailing the recommended actions for those presenting with suicidal behaviours. The UK National Institute for Health and Care Excellence guidelines for self-harm provides a template www.nice.org.au > **NICE Guidelines** > **Conditions and diseases** > **Mental health and behavioural conditions** > **Self-harm**



Recommendations continued

- **Focus on aftercare and postvention for Aboriginal and Torres Strait Islander people** – This may involve working closely with family and kin, and ensuring the involvement of Aboriginal Community Controlled Health Services or other services as appropriate. Ensuring aftercare for people living in remote communities is particularly important. Postvention is important where contagion and suicide clusters are risks following a community-member suicide or suicide attempt. PHNs and Aboriginal and Torres Strait Islander communities should work in partnership to consider what postvention support is available for bereaved families and communities (for examples see ‘Aboriginal and Torres Strait Islander programs’ under Section 6), and plan ahead for postvention responses to suicide.
- **Commission community-based crisis teams** – Available 24/7, these teams can function as the single point of contact for people who are in crisis and provide short-term support until other services are available. Crisis teams that employ Aboriginal and Torres Strait Islander individuals to work in their communities should be a part of this action.
- **Commission the development of locally-based resource packs** – These packs should be distributed to patients and carers upon discharge after self-harm admission. This may include the following resources (please note, a full list of resources is available in Section 6):
 - Details for general and specialist crisis line services
 - eHealth programs
 - The name and emergency contact number for a hospital staff member who was responsible for the individual during their stay in hospital. This may be someone from the Suicide Prevention Team at the hospital.
 - Contact details for mental health crisis or acute care teams
 - Contact details for community allied health professionals such as psychologists
 - Contact details for high-risk population mental health professionals (e.g. Aboriginal and Torres Strait Islander or LGBTI)
 - Support groups for families/carers
 - Any other support services/groups available within the community.
- **Encourage and facilitate patient follow-up** – A continuity of care model involves the local Suicide Prevention Team following up patients monthly for six months, by telephone, letter, or postcard. This recommendation may be particularly effective for those who were admitted for self-poisoning or those who had

a positive experience in hospital. For Aboriginal and Torres Strait Islander people in a vulnerable state, the option should be provided to have follow up provided by an Aboriginal and/or Torres Strait Islander person.

An example model is given below with recommended strategies:

1. **Outreach:** Initiating and maintaining individually tailored contact
 - Follow up within 24 hours after discharge, then again at 7 days
 - Implement a brief contact intervention (telephone, letter, postcard).
 2. **Problem solving:** Solution-focused counselling
 - Psychologist to deliver regular sessions of problem-solving therapy for a fixed time period.
 3. **Adherence:** Motivate and support patient to adhere to recommended treatment
 - Persist in contacting patient to encourage treatment seeking
 - Train Suicide Prevention Team in motivational interviewing to be used as needed
 - Involve both patient and caregiver in treatment and discharge plan
 - Notify and engage patient’s treating GP, Aboriginal Community Controlled Health Services, and mental health professionals in aftercare.
 4. **Continuity:**
 - Ensure continuity of individual care by the same provider for the duration of their care
 - Provide assistance in navigating the mental health system including accessing resources, services, and treatment.
- **Consider the unique needs of rural and remote communities** – Experiences of stigmatisation may be particularly prominent for individuals receiving treatment for self-harm in small community hospitals. Training of front line staff (see Strategy 4) may be helpful in addressing stigmatising attitudes. Lack of consultation psychiatrists or disinclination to use available services may be further barriers to care. PHN partnerships with local health and hospital networks may assist in addressing such issues.
 - **Identify and support LGBTI community members** – PHNs should aim to recommend that hospitals include sexuality and gender indicators for individuals who have made an attempt (see Section 7). This will ensure that individuals of LGBTI communities are identified and provided with specialist LGBTI support if needed.

Strategy two: Psychosocial and pharmacotherapy treatments

Mental illness, diagnosed or undiagnosed, is associated with the majority of suicide attempts. Providing accessible and appropriate mental health care is therefore essential to any suicide prevention plan. The two main therapeutic options include psychosocial and pharmacotherapy treatments, both of which are outlined below.

Psychosocial

Psychotherapy, such as cognitive behaviour therapy and dialectical behaviour therapy, has been found to be effective in reducing suicidal thoughts and behaviours.^{21,22} Psychotherapy is particularly effective for high-risk individuals such as those with borderline personality disorder or patients admitted to an emergency department after a suicide attempt.^{22,23}

Several psychotherapies have been shown to reduce **suicidal behaviour** including:

- Cognitive behaviour therapy for suicide prevention and mentalisation-based treatment – for adults
- Multi-systemic therapy and group therapies – for adolescents
- Dialectical behaviour therapy – for individuals with borderline personality disorder
- Problem solving therapy to reduce repeat hospitalisation – for individuals with a history of prior self-harm
- Psychodynamic interpersonal psychotherapy to reduce repeat attempt – for individuals hospitalised for repeat poisoning.

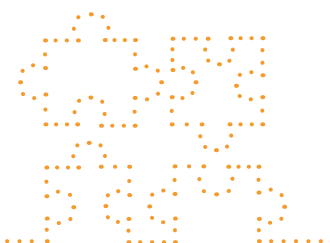
Effective psychotherapies to reduce **suicidal thoughts** include:

- Collaborative assessment and management of suicidality, cognitive behaviour therapy, and psychodynamic interpersonal therapy – for adults
- Attachment-based family therapy – for adolescents.

Pharmacotherapy

Although early studies found that antidepressants do not reduce suicide attempts or deaths more than placebo,²⁴⁻²⁶ more recent studies reported that fluoxetine and venlafaxine decreased suicidal thoughts and behaviours for adult and geriatric patients.²⁷ For youth (18–24 years), no reductions in suicidal thoughts and behaviours were found, although there were reductions in depression symptoms.²⁷ There is a small increase in suicidal thoughts, but not suicides, among young people taking fluoxetine (and perhaps other selective serotonin reuptake inhibitors) for depression, usually during the initial treatment phase, and possibly due to increased agitation as a medication side effect. Higher rates of antidepressant prescribing correlate with reduced rates of suicide in a number of countries,²⁸⁻³⁰ including Australia.³¹ Those countries which had the greatest increase in selective serotonin reuptake inhibitors prescribing have also seen the most marked decline in suicide rates.³² However, the increase in prescription rates may not have necessarily caused the decrease in suicide as other factors (e.g. improved care) may have also contributed to suicide decline. Nevertheless, pharmacotherapy forms part of an overall suicide prevention plan.

The risk of suicide is highest in the month before starting an antidepressant, rapidly declines in the first week of treatment, and continues to decrease at a slower, more stable rate as treatment continues.³³ An increase in suicidality (but not suicides) among adolescents led to the American Food and Drug Administration's black box warning on antidepressant medication for youths in 2004. However, several subsequent studies have shown that as antidepressant prescription rates increase, youth suicides decrease.³⁴⁻³⁶



Recommendations

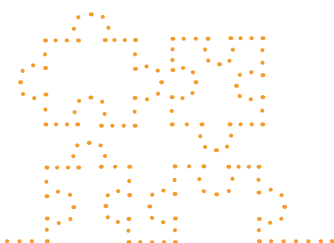
- **Facilitate access to quality mental health care** – Whilst PHNs need to work within the confines of the public health system, there are a number of actions they can take to improve the mental health care of at-risk individuals. These include:
 - Providing the tools and resources (including contact lists for a variety of specialities) to encourage GPs, community health centres, and emergency departments to refer to appropriate speciality care
 - Ensuring local availability of therapists skilled in effective psychosocial therapies and providing quality, evidence-based training for those health professionals keen to upskill
 - Surveying mental health professionals within the region to identify those that have expert knowledge and experience in treatment of suicidal individuals, including for particular issues and groups (i.e. childhood abuse and neglect, Aboriginal and Torres Strait Islander peoples, LGBTI)
 - Promoting evidence based eHealth programs to mental health professionals. Several eHealth programs are available that impact modifiable risk factors for suicide, including depression, anxiety, psychological pain, and hopelessness. Services delivered through eHealth platforms (e.g. internet, mobile app) may be particularly helpful for individuals in rural and remote areas where access to face-to-face services may be limited. See online programs in Section 6.
 - Encouraging mental health professionals to run group therapy for those aged 12–16 years with a history of prior self-harm. The group can address some of the common triggers for suicide in this age cohort, such as poor peer relationships and impaired problem-solving. Six acute group sessions should be followed by weekly attendance at longer term sessions.³⁷
- **Develop tailored recommended treatment guidelines for the region** – PHNs may wish to partner with mental health professionals, experts, and community members to create a recommended treatment guide for use when working with suicidal individuals. These guidelines should be tailored to the region and include:
 - An overview of evidence-based and efficacious treatment options
 - A model of care including specialists that need to be involved and most suitable methods of collaboration to create a multi-dimensional prevention plan
 - Support and consideration for family members and carers
 - Training requirements and schedules for health care professionals
 - An overview of confidentiality and privacy issues, especially for LGBTI individuals and those in rural and remote areas
 - Tailored strategies for Aboriginal and Torres Strait Islanders, developed and administered in partnership with the local Indigenous community
 - Strategies for rural and remote populations that address barriers to continued treatment such as transportation difficulties, cost of treatment, and availability of psychological or social work services
 - Strategies to overcome costing barriers which may prevent individuals in rural and remote settings from filling prescriptions. This may involve enlisting the assistance of charitable organisations.
 - Provision of accurate diagnostic criteria and relevant resources including depression and suicide scales, and sexuality and gender indicators
 - Guidelines on the use of medication with suicidal individuals (see Box 2).



Box 2.

Recommendations for pharmacotherapy use in suicidal individuals

- Treating depression early, using pharmacotherapy, psychological therapy, or a combination of both, is key to preventing suicide.
- Antidepressant medications may be considered for moderate depression and are recommended for severe depression. Those with severe depression are best managed in conjunction with a psychiatrist.
- Those with severe depression and marked impairment, poor response to multiple treatments, or for whom depression is life threatening, may be best managed in an inpatient setting.
- Patients prescribed antidepressant medications need to be monitored fortnightly for side effects and effectiveness in the initial weeks of treatment.
- Suicidal or young patients should be monitored weekly until the risk of suicide has reduced.
- Due to the increased risk of suicidal thoughts among young people prescribed fluoxetine (and possibly other selective serotonin reuptake inhibitors), patients and parents need to be warned of a possible increase in agitation and given advice about what steps to take. This risk is usually time limited. Fluoxetine is the only antidepressant medication recommended for adolescents by the National Institute for Health and Care Excellence guidelines³⁸ and beyondblue.
- Tricyclic and monoamine oxidase inhibitor antidepressants are the most dangerous in overdose, followed by serotonin and norepinephrine reuptake inhibitors, then selective serotonin reuptake inhibitors. For this reason, tricyclic and monoamine oxidase inhibitor antidepressants are normally only prescribed by psychiatrists, and for difficult-to-treat depression.
- For some diagnoses, particular medications have shown clear benefits in preventing suicide. These include clozapine in people with psychotic disorders,³⁹ and lithium therapy for patients with bipolar disorder.^{40,41}
- Pharmacotherapies are never sufficient on their own for patients with suicidality, although they may form part of a more comprehensive risk management plan.



Strategy three: GP capacity building and support

Excellent GP care has been shown to significantly decrease deaths and attempts,⁴² particularly when integrated into a multifaceted suicide prevention program, such as the systems approach. The decrease in total suicide rates related to excellent GP care for suicide is between 22% and 73%, suggesting that primary care physician education and capacity building is one of the most promising interventions to reduce suicide rates.⁴³ After participating in educational suicide prevention

programs, GPs report they have increased knowledge and skills in recognising and helping suicidal patients.^{44,45}

People with suicidal behaviour frequently visit primary care physicians in the weeks or days before suicide, which makes GPs ideal candidates to identify suicidality, even in those not reporting distress. Up to 45% of individuals who died by suicide saw their GP within one month prior to death, and up to 20% within one week before death.^{46,47}

Recommendations

- **Identify, commission and promote skills-based GP education** – All GPs should have access to evidence-based programs focused on screening for suicidality, immediate risk management, and the identification of mental disorders such as depression. Refresher courses should be undertaken every three years. The education should focus on using role plays rather than didactic learning and include the three main components below.
 1. **Knowledge:** Warning signs, risk and protective factors, and referral resources including locale-specific ones such as crisis hotlines, emergency departments, and mental health services for ongoing management.
 2. **Attitudes:** Increasing GP's sense of self-efficacy to work with at-risk individuals, reducing stigma, and increasing knowledge of effectiveness of suicide prevention efforts.
 3. **Skills:** Increase identification of at-risk individuals, confidence in assessing risk level, and referral to additional mental health services. Training of application of brief interventions and standardised measures is also recommended.
- **Promote evidence-based eHealth programs to GPs** – GPs may wish to refer suitable patients to these resources. See online programs in Section 6 for specific details.
- **Encourage understanding of high-risk groups** – Groups such as Aboriginal and Torres Strait Islander and LGBTI communities require special training.
 - GPs should be trained or experienced in the delivery of a culturally competent service to Aboriginal and Torres Strait Islander people, with an understanding of the holistic view of health and mental health held by them. This may involve collaboration with local Aboriginal Health Councils or other relevant committees to determine best training programs. GPs should also undergo LGBTI inclusivity training and be aware of the specialist referral pathways for this group (see Section 7).
- **Facilitate strong collaboration** – GPs, psychiatrists, psychologists and outpatient services should collaborate to increase treatment utilisation. This can be achieved through:
 - Organising panels and roundtable discussions within the community
 - Setting up, or promoting, an online information centre
 - Building up a local information data network to facilitate fast communication. Consultation with community and Clinical Councils, as well as utilisation of the Wesley LifeForce Community Hub resource may be particularly useful (see 'Community Engagement' in Section 7).
- **Include the voice of lived experience** – Inclusion of those with lived experience is essential in the development and delivery of all GP education. Those with lived experience offer a unique perspective in the recognition of suicide warning signs, and importantly, how to respond to patients with sensitivity. See Section 4 for more details on lived experience.

Strategy four and five: Frontline staff and gatekeeper training

Gatekeepers are those people who are likely to come into contact with at-risk individuals, and who might be influential in a suicidal person's decision to access care. They are naturally in a position to carry out informal observation of an individual, detect risk, and provide assistance. This includes frontline staff members such as police and emergency department staff.

Gatekeepers are usually divided into two groups:

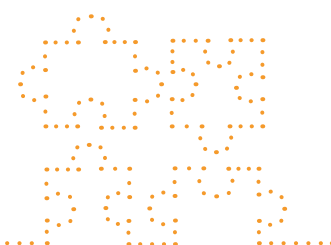
- **Designated gatekeepers** – Formally-trained persons such as GPs, psychiatrists, psychologists, nurses, and social workers.

- **Emergent gatekeepers** – Not formally trained but are potential gatekeepers as recognised by those with suicidal intent, such as police, clergy, pharmacists, teachers, counsellors, family and friends, school and work peers, and crisis line staff.

Many gatekeeper programs focus on increasing mental health literacy through developing knowledge, changing attitudes, building confidence in dealing with suicidal individuals, and teaching skills to assess risk level, manage the situation, and refer when appropriate.⁴²

Recommendations

- **Identify local gatekeepers** – In addition to the professions outlined above, it is recommended that individuals working with high risk populations, such as those with a disability, older people, unemployed, in financial crisis, or those who have experienced torture/trauma or sexual assault, receive gatekeeper training as part of the induction process. In rural and remote areas potential gatekeepers may include individuals from occupation groups such as veterinarians, stock and station agents, bankers, staff of Department of Primary Industries, and managers of heavy industries such as mining and quarrying.
- **Source, subsidise and promote gatekeeper training programs** – Gatekeeper training programs should focus on increasing knowledge, changing attitudes, and teaching skills. While training is available online, face-to-face training is preferable, as is having a strong practical element. Subsidising training will increase uptake. It is recommended that training be conducted through the induction process and refresher courses undertaken every three years. See Section 6 for potential programs.
- **Tackle stigma and include lived experience** – Frontline staff interact with at-risk persons when they are most vulnerable. As such, training needs to focus on reducing stigmatising attitudes and beliefs towards suicide and suicidal individuals. One way of doing this is through the inclusion of stories from lived experience. People with lived experience of a suicide attempt will provide unique perspectives to aid the recognition of suicide warning signs, to respond with sensitivity, and to increase the impact of messages.
- **Provide specialist training where required** – LGBTI inclusivity training and referral pathways for LGBTI clients are recommended (see Section 7). Cultural and age-appropriate materials for use in Aboriginal and Torres Strait Islander communities, and among children and younger people are required.
- **Make gatekeeper training mandatory** – Gatekeeper training could be usefully incorporated into induction programs in settings with high turnaround of front line staff (e.g. rural and remote communities).



Strategy six: School programs

Schools offer an ideal setting for suicide prevention for all young people. They are a cost-effective and convenient way of reaching young people.⁴⁸ Schools could also play a role in reducing Aboriginal and Torres Strait Islander suicide.

Although there is no evidence showing that school based programs prevent suicide deaths, several programs have been shown to reduce suicide attempts and thoughts. A large randomised controlled trial comparing several programs found that the Youth Aware of Mental Health intervention (a mental health literacy program) reduced suicide attempts and lowered the severity of suicidal

thoughts.⁴⁹ The Signs of Suicide program also found that students were 40% less likely to experience a suicide attempt than those not undertaking the program.⁵⁰

Help-seeking is an important factor in suicide prevention. As such, many school-based programs focus on increasing help-seeking behaviour and mental health literacy, and improving knowledge of suicide warning signs and help strategies.^{43, 51-53} The Sources of Strength program, which promotes increased connectedness among peers and adults, has been found to increase help-seeking behaviour and improve acceptability of help seeking.⁵⁴

Recommendations

- **Encourage adoption of evidence-based programs** – The Australian Government currently supports several frameworks for social and emotional wellbeing including KidsMatter (www.kidsmatter.edu.au) and MindMatters (www.mindmatters.edu.au), with movement to a single and integrated framework in the near future.⁵⁵ Within this framework, school-based suicide prevention programs with sufficient evidence for their effectiveness, such as those outlined above (see also Section 6), can be positioned. Cards detailing local healthcare contact information, which staff can distribute to pupils identified at-risk, should be considered.
- **Support LGBTI and Aboriginal and Torres Strait Islander youth** – LGBTI youth experience higher rates of anxiety, depression, and suicide than their peers.¹¹ To better equip the LGBTI population to manage their sexual and mental health, school

programs that address bullying, homophobia, and transphobia should be factored into the school framework. Refer to accredited support services for implementation strategies. Culturally appropriate programs and materials should be made available for young Indigenous people, compiled in partnership with local Aboriginal Health Councils or Aboriginal and Torres Strait Islander community members.

- **Screen for suicide risk-factors** – As part of the overarching mental health framework, schools may consider screening students annually for suicide and depression to identify and monitor those who may be at-risk. Screening must be supported by systems that can review the screening results and take the next appropriate steps, including referral for further evaluation and treatment if necessary. See Section 6 for recommended screening tools.



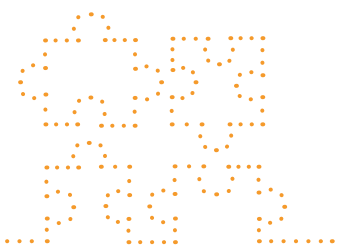
Strategy seven: Community campaigns

Suicide awareness campaigns aim to improve mental health literacy in the general population. This includes increasing the ability to recognise risk, improving help seeking, reducing stigma, and improving understanding of suicide causes and risk factors. Community campaigns are particularly suited to reach at-risk people who would normally avoid help-seeking.

Community campaigns may improve the public's knowledge of suicide rates. A Norwegian mental health campaign focussed on a six-hour national fundraising television program. Prior to the broadcast, there was extensive advertisement of the campaign through newspaper and television networks as well as household letter drops. Ninety four percent of the follow-up sample had heard of the campaign and reported significant increases in knowledge about suicide frequency.⁵⁶

However, there is little evidence to suggest that community campaigns reduce suicidal behaviour. One large-scale flyer-based campaign in Nagoya, Japan, showed a reduction in the rate of suicide. It reduced the total suicide count by one person if flyers were distributed on 15 weekdays per month,⁵⁷ which equates to significant effort for a small reduction.

The general consensus is that suicide community campaigns are best delivered in conjunction with other strategies, such as gatekeeper training and GP capacity building.^{2,3} As a stand-alone intervention, there is insufficient research to determine whether they have any impact on reducing suicide rates or changing suicide behaviours.^{58,59}



Recommendations

- **Identify existing programs** – Community campaigns should only be offered in conjunction with other active strategies. An analysis of current and planned suicide and mental health campaigns across the sector would help coordinate efforts.
- **Collaborate with community** – Repeated exposure to a message is likely to have a greater impact on retention. As such, it is recommended that community members be exposed to consistent suicide awareness messages from multiple community organisations such as workplaces, sports clubs, and community events. Community members should work together and with organisations such as beyondblue to ensure consistency in message delivery.
- **Ensure accurate and targeted messaging** – Suicide issues and risk factors affecting each community are unique. Communities with high-risk populations, such as Aboriginal and Torres Strait Islander or LGBTI, are encouraged to develop their own mental health promotion campaigns which consider the unique community needs. PHNs can encourage this through collaborative and supportive community engagement processes and linkages to community suicide prevention networks (such as Wesley LifeForce Networks). Aboriginal and Torres Strait Islander communities, Aboriginal Community Controlled Health Services, Aboriginal Health Councils, or other relevant organisations need to be involved to ensure that campaigns are age and culturally appropriate to meet the needs of all groups and sub groups in a community (see also Section 3). Campaign messages and materials may need to be translated into Aboriginal and Torres Strait Islander languages.
- **Encourage effective marketing** – Information about the causes and treatments for suicide risk will increase community knowledge. Awareness messages may include suicide warning signs, resources for referral, and sources of help within the local community. Awareness promotion can occur through several mediums including: handing out flyers, distributing newsletters, radio programs, community events, social media, celebrity endorsement, and lived experience spokespeople. PHNs may wish to consult with key members of the community to determine best avenues for the largest reach. Promotion of locally and nationally available crisis services and helplines is essential (e.g. Lifeline, Suicide Call Back Service, etc.).
- **Incorporate lived experience** – Interventions aimed at reducing mental health stigma and discrimination are most effective when they involve an individual with lived experience of mental illness.⁶⁰ That is, when individuals with lived experience speak about mental illness to the community at large, stigma and discrimination are reduced. Individuals with lived experience are an asset to community awareness campaigns. See Section 4 for strategies on how to incorporate lived experience.

Strategy eight: Media guidelines

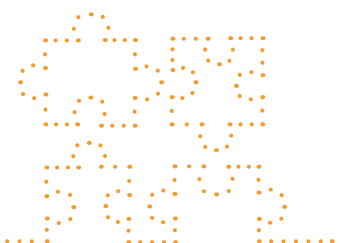
There is extensive literature linking media reporting of suicide with increased suicide rates. Suicidal behaviour can be 'learned' from the media when reports are sensationalised, focus on celebrities, are repeated, and explicitly describe location and method details.⁶¹ These concerns have led to the development of media guidelines which encourage media to report suicide accurately, responsibly, and ethically.⁶²

Evidence suggests that responsible reporting of suicide by the media can reduce suicide rates.^{61,63} Following implementation of media guidelines for news reporting

in Austria in mid-1987, the rate of subway suicide attempts and deaths decreased by 84.2% (for suicide deaths alone there was a 75% reduction) in the second half of 1987.⁶⁴⁻⁶⁶ This decrease was not due to a change in the transportation system or a decrease in the national suicide rate (which actually slightly increased in the second half of 1987).⁶⁵ Subway suicides remained low for 5 years following the introduction of media guidelines.⁶⁶ Such findings demonstrate the effect of a well-designed media reporting intervention on suicide prevention.

Recommendations

- **Adopt and promote Mindframe guidelines** – Mindframe is the national suicide prevention media initiative which provides comprehensive guidelines for the public reporting of suicide deaths and attempts. Local media organisations should be encouraged to follow these guidelines, and face-to-face training can be provided by the Mindframe team. These and other guidelines can be accessed in Section 7. Most guidelines include the below principles:⁶²
 - Report suicide deaths in a sensitive and non-sensationalist manner
 - Avoid giving suicide deaths undue prominence (e.g. front page of newspaper, or lead items in radio bulletins)
 - To prevent 'copycat' incidents, avoid providing specific details about the suicide, such as method or location
 - Take the opportunity to educate the public and challenge myths about suicide
 - Provide help and support resources to vulnerable viewers, such as listing crisis and helpline numbers
 - Consider the needs of at-risk individuals in the aftermath of a suicide (e.g. taking care when interviewing the bereaved)
 - Provide opportunities for debriefing for those exposed to suicide stories, such as journalists themselves.
- **Acknowledge Aboriginal and Torres Strait Islander media** – Include Aboriginal and Torres Strait Islander specific media when considering and implementing media guidelines.



Strategy nine: Means restriction

Restricting access to the means of suicide is considered to be one of the most effective suicide prevention strategies.^{43,67} Significant declines in general suicide rates have been reported after restricting access to firearms, toxic domestic gas, pesticides, barbiturates, erecting safety barriers, and introducing 'safe rooms' (which eliminate suspension points for hanging) in prisons and hospitals.⁴³

A number of studies have reported on the impact of restricting access to suicide methods in Australia. These include limiting access to firearms,⁶⁸ jumping sites,⁶⁹ motor vehicle exhaust,⁷⁰ and means of self-poisoning.⁷¹

The effectiveness of means restriction is quite strong in the case of restricting access to jumping sites and barbiturates. Structural interventions (e.g. barriers and safety nets at jumping suicide hotspots) resulted in a 28% reduction in all jumping suicides annually.⁷²

The decline in rates of suicide in most parts of Australia between 1988 and 2007 coincides with restricted access to lethal suicide methods. In Australia, no evidence of means substitution (i.e. substituting an unavailable suicide method with one that is more readily available) has been found for jumping from heights,⁶⁹ firearms,⁷³ and motor vehicle exhaust.⁷⁰

Recommendations

- **Source and analyse local data** – Measures to prevent suicide through means restriction should be evidence based. As such, PHNs are encouraged to source and analyse data (or commission services to do so) from police, transport authorities, councils, and people with lived experience (see Table 2 in Section 5) to identify means of suicide and the geographical location of these deaths within each PHN. Local knowledge will then dictate the measures needed to prevent further deaths. Areas and buildings within specific locations may need to be modified. The means restriction strategies will then be tailored to these hot spots. Special attention should be paid to Aboriginal and Torres Strait Islander communities.
- **Target specific means** – Hanging is one of the most common suicide methods in Australia.⁸ PHNs should partner with relevant organisations to implement strategies to reduce suicide by hanging. These should focus on the prevention of suicide in controlled environments (such as hospitals), the emergency management of 'near-hanging', and on the primary prevention of suicide in general.⁷⁴ High-risk patients should be given or asked to wear clothes that do not need belts and shoes that do not have laces.⁷⁵
- **Collaborate with community** – Implementation of means restriction strategies will require close collaboration with local councils and other relevant community stakeholders, including with Aboriginal and Torres Strait Islander communities (see Section 3).



“The death of a child to suicide is an enormous tragedy. Our immediate and extended families, friends and our community could not find the words to describe these moments...nothing made any sense. The loss of a child to suicide is one of the most devastating of all human experiences. Engagement with Aboriginal and Torres Strait Islander communities is critical to the success of suicide prevention among our members.” – JULIE TURNER, FOUNDER, MOTIVATIONAL MINDS

Section 3 – Aboriginal and Torres Strait Islander communities

This section is designed to provide guidelines for suicide prevention activities for Aboriginal and Torres Strait Islander peoples. Many population sub-groups with unique needs (such as LGBTI, those who misuse alcohol and other drugs, rural and remote) also

require a targeted approach. However, the research evidence for these is not yet established enough to make recommendations. A large body of research has emerged with respect to suicide prevention within Aboriginal and Torres Strait Islander groups.

Cultural competence and cultural safety

Services that are not culturally competent and safe, including services involved in suicide prevention, indirectly discriminate against Aboriginal and Torres Strait Islander peoples by placing cultural barriers in the way of their right to enjoy the same services as other Australians.⁷⁶

Cultural competency skills can be gained in two ways: Through experience in working with Aboriginal and Torres Strait Islander peoples, or via training modules.

Cultural competency skills include the below.

- **Cultural awareness:** Understanding the role of cultural difference and diversity. For non-Indigenous staff this requires a capacity for self-reflection as to how the dominant Western culture impacts both themselves and Aboriginal and Torres Strait Islander peoples, and how it can impact the service setting in which they operate.⁷⁷

- **Cultural respect:** Building respectful partnerships and valuing Aboriginal and Torres Strait Islander peoples and their cultures, including a commitment to their self-determination.
- **Cultural responsiveness:** Having the ability and skills to assist people of a different culture.

Culturally safe service environments ‘with no assault, challenge or denial of their identity, cultural rights, values or beliefs’ are welcoming for Aboriginal and Torres Strait Islander peoples. The visible presence of Aboriginal and Torres Strait Islander staff has been demonstrated to increase the accessibility of services by contributing to a sense of cultural safety, and otherwise helping to acculturate the service.⁷⁸



PHN engagement with Aboriginal and Torres Strait Islander communities

Effective engagement and partnership with Aboriginal and Torres Strait Islander communities is critical to the success of suicide prevention among their members. A PHN should ensure a community is in the 'driver's seat' and work in partnership with the community when conducting needs assessments and commissioning and evaluating programs and services to that end. PHNs must also respect Aboriginal and Torres Strait Islander peoples' right to self-determination in matters that affect their communities, including (but not limited to) suicide prevention.⁷⁹

Such collaboration will also help to effectively implement the 2013 *National Aboriginal and Torres Strait Islander Suicide Prevention Strategy*, a resource that PHNs may find useful and available for download at www.health.gov.au > Resources > Publications.

The establishment of the Western NSW PHN Aboriginal Health Council

This segment may be relevant for those PHNs wanting to establish Aboriginal Health Councils.

Of the 31 PHNs in Australia, Western NSW PHN (WNSW PHN) is the only PHN that has an Aboriginal Health Council. On 10 March 2016, the Aboriginal Health Council held its inaugural meeting.

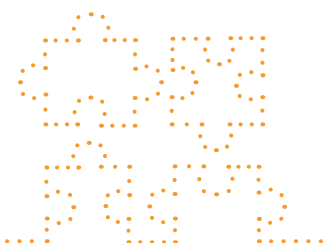
The development of the WNSW PHN Aboriginal Health Council was identified as an important strategic initiative by the Consortium in their application to establish the WNSW PHN. The Consortium partners included Western NSW Medicare Local, Far West Medicare

Local, Maari Ma Health Aboriginal Corporation, and Bila Muuji Health Services.

It was decided that in partnership with the region's Aboriginal communities, the WNSW PHN would establish an Aboriginal Health Council to build on the significant engagement of Aboriginal Community Controlled Health Services through the Consortium and further support their strategic alliance across the region. Aboriginal people make up 11.8% of the region's population compared with 3.0% across NSW.⁸⁰

The Aboriginal Health Council is a skills based council whose role and function specifically relates to assisting in the engagement and development of the Aboriginal Community Controlled Health Services provider networks. The council also provides advice to the Board to ensure there is a culturally aware and competent critique on matters relating to the design and development of services for Aboriginal people. Additionally, the council provides strategic guidance on matters relating to Aboriginal health at the state and national levels including policy, legislation, and funding.

The Aboriginal Health Council also provides a critical point of contact for the Health Intelligence Unit, the Clinical Councils, and Community Councils to advise the Board on the PHN national key priority areas of Aboriginal health, mental health, population health, health workforce, digital health, and aged care.



Respecting the differences

PHNs should avoid the mistake of assuming general population suicide prevention activity is enough to meet the needs of Aboriginal and Torres Strait Islander communities. While Aboriginal and Torres Strait Islander communities can, and should be able to benefit from general population suicide prevention activities (such as the range of strategies in the systems approach), this is unlikely to meet the full range of their complex and diverse needs.

In particular, dedicated suicide prevention activities are needed to account for cultural differences between diverse Aboriginal and Torres Strait Islander communities and the general population. This includes differences in:

- Community and family organisation and governance
- Understandings of health, which is viewed as a holistic concept known as social and emotional wellbeing within Aboriginal and Torres Strait Islander communities. This broadly connects the physical health, mental health and wellbeing of an individual to the health of their family and kin, community, culture, country and the spiritual dimension of existence.⁸¹
- Health-supporting practices, such as that provided by cultural healers.

The historical and present-day impacts of colonisation on Aboriginal and Torres Strait Islander individuals, families, and communities has resulted in a range of challenges faced by Aboriginal and Torres Strait Islander communities that are not generally faced by other Australian communities. Therefore, dedicated and community-specific responses are required.

Aboriginal and Torres Strait Islander peoples report psychological distress at three times the rate of the general population.⁸² Indeed, there is a broader mental health 'gap' across many indicators,⁸³ with suicide being only one of these indicators.

This situation is compounded by Aboriginal and Torres Strait Islander peoples' lower access to primary mental health services.^{82,84} This might be due to a lack of physically or economically accessible services, or Aboriginal and Torres Strait Islander peoples' reluctance to use those available services because the environments are not culturally safe or the staff are not culturally competent in service delivery.

Universal and selective prevention activity

'Universal prevention activity' in this context refers to Aboriginal and Torres Strait Islander community or population wide activity (e.g. strategies 7, 8, and 9 in Section 2). 'Selective prevention activity' refers to activities targeting sub-groups at-risk of suicide within Aboriginal and Torres Strait Islander communities or within the Aboriginal and Torres Strait Islander population, such as young people (for example, strategy 6 in Section 2).

The broadest universal response to suicide in Aboriginal and Torres Strait Islander communities involves mitigating the impact of negative social determinants that are also suicide risk factors. Communities might face a range of challenges, and/or have different priorities among them.^{85,86} Here PHNs can play an important supporting role by providing education and other support to enable communities to take the lead in identifying and prioritising their needs, and to plan and develop responses at both the universal and selective levels.

Needs identified might include:

- Conflict resolution skills training to help stop family feuding within a community
- Reducing alcohol and drug use in the community
- Cultural reclamation work to support social and emotional wellbeing and 'cultural continuity', which has been found to be protective against youth suicide in Canadian Indigenous communities.^{87,88} These findings are supported by work in Aboriginal and Torres Strait Islander community settings.⁸⁴
- Addressing the developmental factors that can predispose Aboriginal and Torres Strait Islander children and young people to suicide. This might include cultural and age appropriate school programs about relationship issues and how to handle break-ups, or reducing the use of drugs and alcohol.

Supported by PHNs, communities might be best placed to conduct situational analyses to support more focused universal suicide prevention activity. This might include considering:

- The range of strategies in the systems approach to suicide prevention as they might apply to a community (see Section 2).
- What levels of intervention are needed? Universal, selective, indicated? If selective, which population sub-groups in particular? If indicated, how will the community work to establish and sustain their presence?
- What are the immediate, medium and longer term priorities?
- What are the main causes of suicide in the community?
- What lethal means are being employed by those who attempt or die by suicide?
- What is the appropriate balance of cultural and clinical approaches, and will this change over time?
- Does the community require mental health literacy training to reduce stigma, encourage help seeking, and identify those at-risk?

- What resources are available to the community to respond to a suicide in a culturally safe and timely manner?

The aim of such an analysis is to produce a community plan with goals set at appropriate milestones in order to support accountability. The plan should be agreed upon by the whole community. Importantly, the content, design, and delivery of plans and responses must have community support, and be culturally appropriate.

Responses and plans should optimally aim to have multiple beneficial impacts. Such impacts may include:

- Employing community members
- Strengthening or helping to establish Aboriginal Community Controlled Health Services
- Creating or strengthening men's, women's, and youth groups
- Involving elders
- Supporting culturally-informed governance structures.

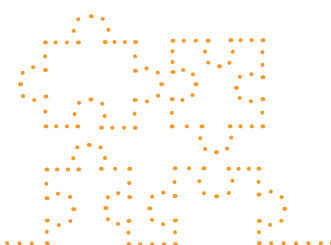
Indicated services

Indicated strategies target specific individuals within the population who have been identified as high-risk, such as those showing early signs of suicide potential (e.g. recent suicide attempt).

The cultural safety of service environments for vulnerable Aboriginal and/or Torres Strait Islander people at-risk of suicide is particularly important, as is the cultural competence of professional staff and others in the service. Ideally, a vulnerable Aboriginal and/or Torres Strait Islander person at-risk of suicide will be able to access treatment or support from an Aboriginal and/or Torres Strait Islander staff member, and/or one of their own gender or sexual identity.

At this level, PHNs should work in partnership with State and Territory mental health services as well as Aboriginal and Torres Strait Islander mental health consumers to develop service models. These service models should:

- Enable access to clinical and culturally-informed treatment options
- Provide avenues of social support
- Help ensure effective transitions for Aboriginal and Torres Strait Islander mental health consumers from community-based primary mental health settings to specialist treatment and then back again to community primary mental health care settings.



Critical points of engagement

To encourage successful suicide prevention activity in Aboriginal and Torres Strait Islander communities, PHNs should ensure that members of communities are placed in empowered positions – in the ‘driver’s seat’ – and that they engage and partner with them. Critical points of engagement for PHNs are when they:

- Undertake a needs assessment regarding both the prevalence of suicidal behaviours and service/response gaps.
- Commission a service or program that addresses Aboriginal and Torres Strait Islander issues. Such service or program must be acceptable to the Aboriginal and Torres Strait Islander communities it is intended to serve.
- Evaluate a service or program. The Aboriginal and Torres Strait Islander communities they are intended to serve should be engaged in the evaluation process and their views taken seriously and given priority.

Recommendations for effective engagement

- Be proactive – reach out to communities rather than waiting to be contacted.
- Ensure Aboriginal and Torres Strait Islander peoples are employed at all levels of a PHN’s organisational structure. This has shown to be effective in helping to acculturate services to work effectively with Aboriginal and Torres Strait Islander peoples.
- Require cultural competence training of all non-Indigenous staff.
- Appoint dedicated officers, preferably local Aboriginal and/or Torres Strait Islander persons, to oversee engagement with communities.
- Aboriginal Community Controlled Health Services (where available) not only provide good points of contact with communities for all health and related matters, but are ideally placed for PHNs to partner with and support their work in communities. Where possible, commissioned services should be integrated with primary mental health, social and emotional wellbeing, and alcohol and drug use reduction services already provided by the Aboriginal Community Controlled Health Services.
- Appoint PHN board members who are Aboriginal and/or Torres Strait Islander and have expertise in the issues facing communities for which the PHN is accountable to.
- Ensure that Community Advisory Committees and Clinical Councils include Aboriginal and/or Torres Strait Islander members with expertise in the issues facing the communities the PHN is accountable to, including remote communities if relevant.
- Establish an Aboriginal and/or Torres Strait Islander community advisory subcommittee to ensure a range of diverse Aboriginal and Torres Strait Islander voices contribute to the committee’s deliberations.
- Encourage PHN boards, Community Advisory Committees, and Clinical Councils to have protocols in place which ensures the cultural safety of their Aboriginal and Torres Strait Islander members. Examples might include:
 - Incorporate Aboriginal and Torres Strait Islander issues (including suicide prevention) as standing items on meeting agendas. This ensures they are not inadvertently subsumed and marginalised in general population concerns.
 - Have at least two Aboriginal and/or Torres Strait Islander people present in any forum.
 - Provide financial or transport support to attend meetings, particularly for people from remote areas.
 - Provide other support as needed within their roles.
- Ensure that Community Advisory Committees develop an overarching Aboriginal and Torres Strait Islander community engagement strategy that is designed, delivered, and evaluated under Aboriginal and Torres Strait Islander leadership.
- Develop protocols for working with particular Aboriginal and Torres Strait Islander communities reflecting the diversity among them e.g. working through Aboriginal Controlled Community Health Services, or other services and recognised governance bodies.

Section 4 – Community engagement

Local approaches to the issue of suicide should start and end with robust community engagement strategies. In short, services reflecting local cultural practices should be demanded by, embraced by, owned by, and driven by local communities.

The following information and resources relate to important elements of effective community engagement. They can be used by PHNs, commissioned service providers, and individuals involved in suicide prevention initiatives in their communities.

Commissioning external providers

PHNs should commission service providers who can demonstrate alignment to the principles outlined in this community engagement resource and who have a successful track record in either suicide prevention and/or intervention. Important factors to note about using external providers to engage communities are below.

Gauging community change readiness

Communities vary in their readiness to engage. Some communities don't put a high value on the need to engage to bring about change. Others put a high value on the need to change, already have suicide prevention initiatives in play, and will accept engagement with open arms.

PHNs may consider commissioning external service providers who understand and demonstrate the need to gauge the change readiness of communities, before investing resources in engagement.

Commissioned service providers should follow a process of community consultations to seek input and determine interest and readiness. Insights can be derived in various ways ranging from informal conversations through to formal qualitative (e.g. one-on-one or group discussions) or quantitative (e.g. surveys) research techniques. PHNs may wish to share their own community engagement strategies with commissioned service providers.

Building capacity

Commissioned service providers should demonstrate an appropriate methodology to identify existing capabilities and strengths within the community. This may involve a capabilities and strengths audit to document strengths and identify gaps. Once capabilities are identified, efforts should be made to leverage and reinforce the

strengths, and build capabilities where gaps relating to the intended service have been identified.

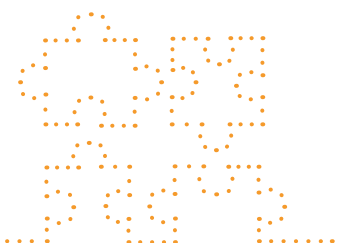
Commissioned service providers should demonstrate a process to address gaps in community capacity. This may be through activities such as:

- Organisational development (policies and procedures, strategic and risk management support)
- Workforce development (training, supervision)
- Leadership development (interpersonal skills development, team building)
- Resource allocation (financial, HR, decision making tools).

Service providers should also demonstrate a track record in running initiatives that are sustainable for the medium to long term. Knowledge and experience of successful social enterprise funding models is one way for service providers to demonstrate acumen in building an initiative's long term prospects by helping to reduce reliance on government funding sources.

Working with others

Successful community initiatives usually involve collaboration. PHNs should commission service providers who can demonstrate a track record in partnering with other organisations and individuals in the delivery of services. Tapping into the resources and expertise of others helps service providers make more efficient and effective community impacts and will usually result in a better experience for service beneficiaries.



Accessing existing community resources

There are a range of resources supporting local suicide prevention initiatives in communities across Australia. Examples of such resources that PHNs and commissioned service providers can access are suicide prevention networks and training (see Section 7).

Suicide prevention networks

These networks bring together key members of service organisations and individuals with an interest in suicide prevention. They can be particularly effective if run by local people who are united in developing and implementing solutions specifically tailored to local issues.

Networks usually focus on achieving one or more of the following outcomes:

- Supporting vulnerable individuals, families, and groups
- Increasing the wellbeing, resilience, and social connectedness of the entire community
- Reducing stigma about the issue of suicide and about seeking help
- Preventing further deaths by suicide.

Incorporating lived experience

The term 'lived experience' is used to describe the first-hand accounts of people who have made a suicide attempt or experience suicidal thoughts. Lived experience also refers to the individuals who support those who have attempted and/or died by suicide. Individuals with lived experience use their expertise to improve services for others. Lived experience is considered to be an important facet in the success of an integrated, multilevel approach, particularly in respect to achieving cross-sector buy-in and enhancing collaboration.

Contributions from lived experience can include assisting other individuals to work systemically with teams, groups, services, organisations, and governments; and working in partnerships to clarify and address the ways in which policies and practices can be strengthened or altered to support people and communities.

Recent studies indicate that working with persons with lived experience provides a number of benefits for clients, practitioners, communities, and health organisations including:

- Serving as recovery role models and mentors for others
- Representing needs in the service system through the lens of lived experience
- Broadening the capacity of the system to be person-centered, family inclusive, and culturally competent
- Providing information and motivation for others
- Increasing the effectiveness of stigma reduction campaigns⁶⁰

- Refuting biases and stigmas regarding the ability of persons with lived experience to lead independent and productive lives.

In the highest form of inclusion, individuals with lived experience are invited as partners in key positions that have decision-making authority and receive compensation for their time and expertise. When agencies and organisations develop supportive environments, people may feel safer with openly using their lived expertise.

The following examples illustrate ways to increase inclusion, by recruiting individuals with lived experience to:

- Join as members of boards of directors, leaders, staff and volunteers
- Participate in oversight or advising systems change
- Review communication campaigns or social marketing endeavours aimed at consumers
- Act as spokespersons, advocates, or resources for others
- Be partners in the development of research and evaluation of suicide prevention initiatives.

When engaging people with lived experience, service providers should be mindful of their duty of care to ensure such people are sufficiently well to participate and are not harmed by their participation. See 'Community engagement' in Section 7 of this document for more information on how to safely and effectively include the voice of lived experience.

Integrating local approaches with wider expertise

Locally-coordinated approaches work most effectively when informed by, and integrated into, best practice in suicide prevention. There are a number of organisations in Australia that demonstrate best practice, and also

provide useful resources and tools. Many of these have local outlets that can be utilised. See Section 7 for more information on these programs.

Working with Aboriginal and Torres Strait Islander communities

Working in partnership with Aboriginal and Torres Strait Islander communities to evaluate suicide prevention programs and services that serve them is a critical element of effective engagement with those communities. Equally important is the need to identify

those services or programs which are not being provided to a community. For recommendations on effective engagement with Aboriginal and Torres Strait Islander communities see Section 3.

Appropriate language to reduce stigma

Effective engagement with local communities on suicide prevention initiatives involves talking about suicide in ways that reduce stigma and increase understanding and support for those thinking about suicide or who have been affected by suicide. Certain ways of describing

suicide can alienate members of the community or inadvertently contribute to suicide being presented as glamorous or an option for dealing with problems. Some suggestions are provided in Table 1.

Table 1.
Preferred and problematic language usage when speaking about suicide

Issue	Problematic	Preferred
Language that presents suicide as a desirable outcome	'successful suicide', 'unsuccessful suicide'	'took their own life', 'ended their own life', 'died by suicide', 'suicided'
Phrases that associate suicide with crime or sin	'commit suicide', 'committed suicide'	'died by suicide', 'took their own life', 'ended their own life', 'suicided'
Language that glamourises a suicide attempt	'failed suicide', 'suicide bid'	'made an attempt on his life', 'suicide attempt', 'non-fatal attempt'
Phrases that sensationalise suicide	'suicide epidemic'	'higher rates', 'increasing rates', 'concerning rates'
Gratuitous use of the term 'suicide' out of context	'suicide mission', 'political suicide', 'suicide pass' (in sport)	Refrain from using the word 'suicide' out of context



Section 5 – Measurement of outcomes



Evaluation is crucial to understanding the efficacy of the systems approach framework within PHNs. Commissioned service providers need to demonstrate experience in service delivery where data is captured at the outset. This allows PHNs and service providers to monitor whether desired outcomes are achieved and to track changes over time. Evaluation will, at the minimum, need to consist of both primary and secondary outcomes, but would ideally also include process and/or implementation evaluation.

As with all datasets, those associated with suicide outcomes have limitations. Such limitations include difficulties in determining intent at the time of death; substantial delays in obtaining data; and problems defining suicide attempt, self-harm, non-suicidal self-injury, and suicidal behaviours. These may lead to some data not being captured, for example, untreated and unreported suicide attempts. While these limitations are genuine, by using multiple data sources it is still possible to examine changes over time.

Primary outcome measures

Measuring changes in rates of suicide deaths and attempts is at the forefront of the evaluation strategy. This can be achieved by comparing data before implementation of the systems approach with data after implementation (called a pre-post evaluation). Since suicide deaths are uncommon, a large population size, such as that encompassed by many PHNs, is needed to determine whether the systems approach significantly reduces suicide outcomes. Suicide attempts are approximately 25 times higher than suicide deaths, although reliable data is limited to hospital admissions for deliberate self-harm and ambulance attendances for suicidal behaviour. There will also be untreated suicide attempts that are not captured in any currently collected dataset. Data for suicide deaths can be obtained through the sources listed in Table 2.

Table 2.

Currently collected datasets relevant to primary and intermediate outcomes

Outcome	Datasets	Custodian	Accessibility	Limitations
Suicide	National Coroners Information System	Coroners	Difficult	Rare event so only suitable for larger populations; can take up to 2 years for coronial findings
	Causes of Death, Australia (3303.0)	Australian Bureau of Statistics	Available at jurisdictional level, lower level requires application	As above
	Mortality data	State registry of Births, Deaths and Marriages	Requires application	As above
Suicide attempt or self-harm	Hospital admissions	Australian Institute of Health and Welfare	Available at jurisdictional level, lower level requires application	Does not capture emergency department presentations or untreated episodes
	Presentations to emergency departments	State Health Departments	Requires application	Not all episodes will be recorded
	Ambulance callouts	State Ambulance Services or Turning Point Victoria	Requires application	Data is only available by application; not all data is cleaned and coded
	Police data	State Police Departments	Requires application	Jurisdictional differences in data collection
Treatment provided by mental health professionals	Medicare Benefit Schedule (MBS) statistics	Department of Human Services	Available at jurisdictional level, lower level requires application	Only captures MBS funded treatment
	Ambulatory mental health datasets	State Health Departments	Requires application	Not available in all jurisdictions
Prescribing	Pharmaceutical Benefits Scheme (PBS)	Department of Human Services	Available at jurisdictional level, lower level requires application	Only captures PBS funded prescriptions
Crisis line use	Calls to help lines	Lifeline, Suicide Call Back Service, MensLine Australia, Kids Helpline	Requires application	Data collection is variable, not all calls will be suicide related



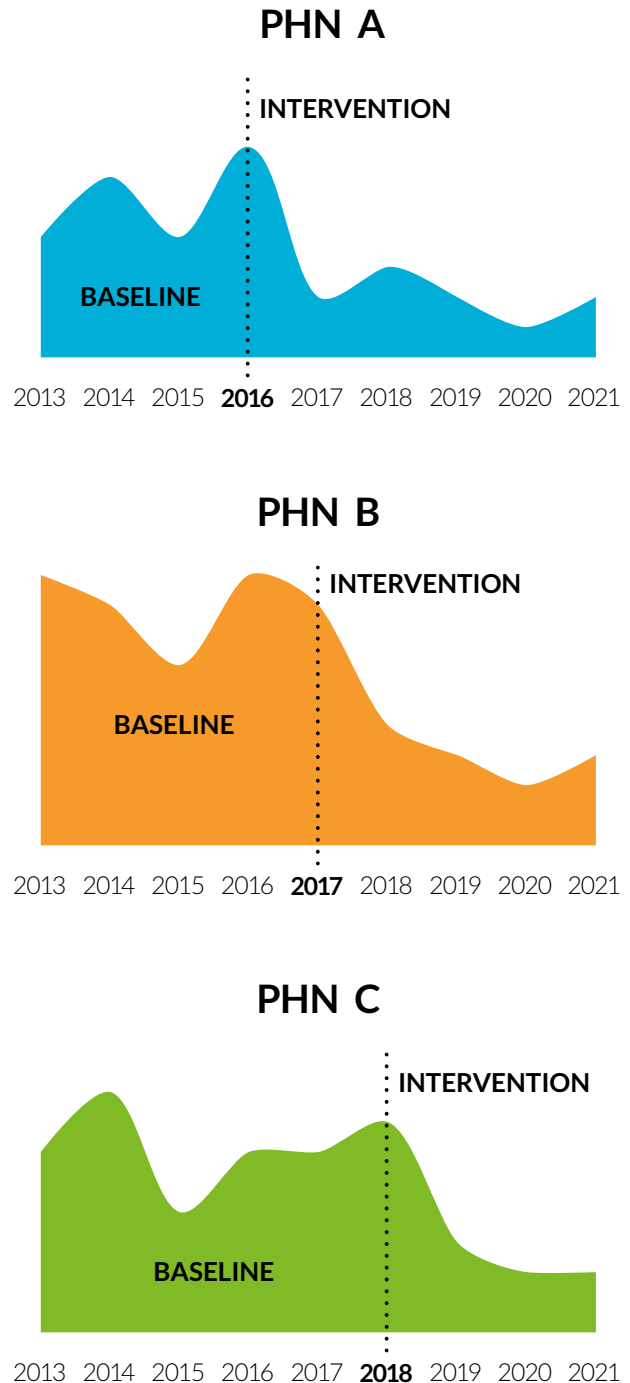
In order to undertake primary outcome evaluation, it is necessary to obtain data before the implementation of the systems approach (pre-implementation) as well as acquiring data for a period after implementation (post-implementation; see Figure 5).

Ideally, pre-implementation data will be acquired for the 10 years before the implementation period, to understand the trend and any normal fluctuations in suicide deaths and attempts. As with the implementation of any strategy, it takes time to see an effect. As such, post-implementation data should be collected for a minimum of 5 years (but ideally, data collection should be on-going), to determine the efficacy of the strategy, and whether its effects are maintained. The efficacy will be determined using time series analysis, which would normally be done by a statistician or researcher. Each PHN will need to acquire data for their own region, and the geographic region will need specified data custodians at the time of acquisition. Given that PHNs have large populations, this is likely to minimise confidentiality issues around small numbers of deaths and/or attempts. As such, PHNs should aim to acquire additional data related to gender, sexuality, and Indigenous status to understand changes in specific at-risk sub-populations.

For effective planning and responses to Aboriginal and Torres Strait Islander suicide, it is important that a PHN is able to distil data for suicidal behaviour in Aboriginal and Torres Strait Islander communities, down to the community level within its jurisdiction. This may involve accessing the ABS data organised by 'Indigenous Structure' down to the level of 'Indigenous Locations (ILOCs)'. Should confidentiality be a concern, it is recommended that protocols be put in place to ensure that the data is not misused nor communities targeted within the media. Privacy concerns must be weighed against the potential benefit that may result from being able to target resources most effectively and according to need. Priority and immediate effort should be directed to those communities where suicides have recently occurred rather than to communities where suicides have not occurred.

Figure 5.

A hypothetical example of expected changes across three PHNs who implemented the systems approach at different times



Secondary outcome evaluation

In order to further measure the effectiveness of a systems approach model, secondary outcomes associated with each of the nine strategies need to be assessed. This will provide valuable information on the efficacy of the individual strategies, and will be used to identify which strategies have optimal impact on the key outcome measures of suicide deaths and attempts, and how strategies might be modified. Intermediate outcomes may include:

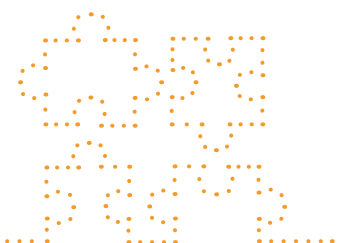
- Changes in the awareness of suicide-related knowledge (e.g. protective and risk factors) among health professionals, the community, and schools
- Changes in the types (and volumes) of drugs prescribed by GPs to treat underlying mental health conditions associated with suicidal intent, such as depression (e.g. change from tricyclics to safer and more effective selective serotonin reuptake inhibitors)
- Increased referrals to psychologists and/or psychiatrists
- Number of calls to emergency hotline and/or crisis services
- Emergency services callouts to local suicide 'hotspots'
- Content of media reports on suicide analysed pre-post intervention to determine extent of alignment with the Mindframe guidelines
- Increased mental health literacy and help seeking among high-school students including longer-term effects of literacy on suicide attempts and deaths.

As with the primary outcome evaluation, data will need to be collected before and after implementation to assess change. Where available, data should be collected for as many years as possible pre-implementation. Measures capturing changes in knowledge are unlikely to have been collected for any significant length of time prior to implementation; therefore, PHNs should start to assess pre-implementation knowledge as soon as possible.

PHNs should adopt standardised measures (i.e. administered and scored in a consistent and pre-determined manner) to assess pre and post change within each organisation on all secondary outcome measures. By using the same measures, comparisons can be made across PHNs to determine how the systems approach model is performing, and what strategies work best in different PHNs. Measurement tools and scales used in Aboriginal health and other services, and those acceptable to other at-risk groups, should be considered and pretested before use to make sure the data collected is accurate and valid.

The instruments used to collect data among sub-populations should be calibrated to the standard tools if at all possible. The same principle applies to standard scales currently used in services serving particular populations, such as corrective services or schools. Examples of freely available standardised measures include:

- Suicidal Ideation Attributes Scale (SIDAS) – measures changes in suicidal thinking
- Patient Health Questionnaire-9 (PHQ-9) – measures changes in depression
- Suicidal Behaviours Questionnaire-Revised (SBQ-R) – measures changes in suicidal behaviour
- Stigma of Suicide Scale (SOSS) – measures individual, organisational, and community views of suicide
- Literacy of Suicide Scale (LOSS) – measures individual, organisational, and community knowledge about suicide.





Process or implementation evaluation

The aim of the process evaluation is to ensure that the systems approach intervention fosters the appropriate level of professional, community, and political commitment (i.e. community capacity building). It also ensures that the strategies are well integrated into existing mainstream healthcare systems, and are therefore sustainable.

The information gathered through the process evaluation will be used to assist in comparing and understanding differences in outcomes between the intervention sites. In order to evaluate the implementation process, key stakeholders or organisations in each PHN should be interviewed at regular intervals to discuss the points listed in Box 3.

Additionally, as part of the process evaluation, it is recommended that the number of activities that form part of the intervention (e.g. public events, leaflets distributed, training sessions held) should be documented in the intervention regions to enable examination of the extent and type of activities that had the biggest impact on primary and intermediate outcomes. This data will form part of the understanding of what works, for whom, and in what context.⁸⁹

Box 3.

The expected outcomes of a process evaluation

Data about the process of implementation will provide valuable information regarding:

- Barriers to implementation (e.g. attitudes, lack of funding)
- Fidelity of the implementation across the intervention regions
- Characteristics of the local environment that may influence implementation
- Availability of local healthcare structures and resources through which strategies can be implemented
- Pre-existing or ongoing local actions targeting suicide which may ultimately impact on the efficacy of the systems approach intervention
- Funding and/or support availability.



“The resource material for implementing a systems approach will provide a framework for organisations and individuals to take community actions that promote deep seated ownership of suicide prevention as an everyday action of community inclusion and care.”

— ANDREW HARVEY, CEO, WESTERN NSW PHN

Section 6 – Evidence-based programs available in Australia

The resources in this section have support for their effectiveness from the research literature. Evidence in support of particular strategies accumulates over time, therefore, it is possible that additional strategies will be added in forthcoming editions. The level of supporting evidence for available strategies is classified as per below.

Table 3.
Levels of evidence

Rating	Research methodology and outcomes
A	Intervention has been shown in a randomised controlled trial to reduce suicidal behaviour
B	Intervention has been shown in a randomised controlled trial to reduce suicidal thoughts
C	Pre-post study has shown a reduction in suicidal behaviour or thoughts
D	Intervention includes evidence-based strategies to reduce behaviour and/or thoughts
E	Intervention has been shown to reduce risk factors such as depression, anxiety, stigma, or to modify help-seeking intentions
F	Tested with the specific population, e.g. youth

Online programs that have effects on suicidal thinking/behaviour

- B SHUTi: An online program for insomnia using cognitive behaviour therapy. This program has been shown to significantly reduce suicidal thinking in a community sample of individuals with sleep problems, and results are maintained for 6 months. For more information about the program visit <http://shuti.me/>. There is a fee for using this program and the Black Dog Institute have partnered with the creators of the program to offer a discounted fee to Australians. For more information go to www.blackdoginstitute.org.au > Getting help > SHUTi
- D BeyondNow: A safety planning app designed to help people reduce their immediate risk of suicidal behaviour. Ideally, this app is used with a clinician. Find out more at www.beyondblue.org.au/beyond-now

Online programs that reduce depression and anxiety (risk factors for suicide)

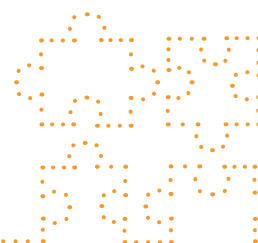
- E myCompass: A self-help program for mild to moderate symptoms of depression, anxiety, and stress. myCompass significantly reduces mild-to-moderate symptoms of depression, anxiety, and stress, and improves work and social impairment. These gains have been shown to be maintained for 3 months. Available on desktop, tablet, and mobile phone. Sign up at www.mycompass.org.au
- E MoodGYM: A cognitive behaviour therapy program that provides skills for preventing and dealing with depression through an interactive web based program. Research shows that MoodGYM reduced depression and anxiety symptoms and these benefits still last after 12 months. To find out more visit www.moodgym.anu.edu.au
- C This Way Up: Provides several online cognitive behavioural therapy courses including treatment for depression, anxiety, and stress. This Way Up courses have been shown to reduce symptoms and psychological distress. Available on desktop and mobile phone for a fee. To learn more visit www.thiswayup.org.au
- E Ecouch: An interactive web-based program with modules for depression, generalised anxiety and worry, social anxiety, relationship breakdown, and loss and grief. Evidence shows it is beneficial for reducing depressive symptoms. To register go to www.ecouch.anu.edu.au

GP capacity building and support

- D Advanced Training in Suicide Prevention: This accredited program, is available for primary care clinicians. The course aims to help participants to undertake a suicide risk assessment effectively and develop a collaborative management plan. To download the course description [PDF] go to www.blackdoginstitute.org.au > **For Health Professionals > GPs > Advanced Training in Suicide Prevention**
- D Training for healthcare workers: This program provides trainees with a greater understanding of risk assessment, suicide prevention, intervention strategies, and patient support and management. Find out more at www.wesleymission.org.au > **Our services > Wesley Mental Health Services > Wesley Suicide Prevention Services > Suicide prevention – Wesley LifeForce training > Healthcare Workers training**

Gatekeeper training – general public

- E Applied Suicide Intervention Skills Training (ASIST): A two-day interactive workshop in suicide first-aid. ASIST teaches participants to recognise when someone may be at-risk of suicide and work with them to create a plan that will support their immediate safety. For more information go to www.livingworks.com.au > **programs > ASIST**
- E Mental Health First Aid (MHFA): The 12-hour MHFA course teaches adults how to provide initial support to individuals who are developing a mental illness or experiencing a mental health crisis. Mental health crisis situations covered include suicidal thoughts and behaviours, and deliberate self-harm. Find out more at www.mhfa.com.au
- E Question, Persuade, Refer (QPR) training for individuals and organisations: Offers online and face-to-face courses for gatekeepers. A range of ongoing courses, such as risk assessment and management are also offered. For more information visit www.qprinstitute.com



Gatekeeper training – workforce and frontline staff

- E Suicide Prevention Skills Training Workshop for workforces: This course, delivered by The Australian Institute for Suicide Prevention and Research, is for workplaces and organisations. It helps individuals attain knowledge and skills in suicide prevention across prevention, intervention, and postvention. For more information go to www.griffith.edu.au > **Health > Research > Australian Institute for Suicide Research and Prevention > Programs and courses > Suicide prevention skills training**
 - E Question, Persuade, Refer (QPR) Gatekeeper training for individuals and organisations: Offers online and face-to-face courses for gatekeepers. A range of ongoing courses, such as risk assessment and management are also offered. For more information visit www.qprinstitute.com
 - E Applied Suicide Intervention Skills Training (ASIST): A two-day interactive workshop in suicide first-aid. ASIST teaches participants to recognise when someone may be at-risk of suicide and work with them to create a plan that will support their immediate safety. For more information go to www.livingworks.com.au > **programs > ASIST**
 - E General Awareness Training component of Mates in Construction: A 45-minute universal intervention which increases awareness of mental health and suicide in the construction industry. The program improves knowledge regarding warning signs, and encourages workers to offer support to co-workers who display suicide warning signs. To find out more go to matesinconstruction.org.au > **About us > How MIC works**
-

School programs for suicide prevention

- A Signs of Suicide (SOS): A 90-minute online training course for middle and high school staff members looking to deepen their understanding of youth mental health. To access the course go to mentalhealthscreening.org/gatekeeper. The Australian National University and the Black Dog Institute have staff who have been trained in the delivery of this program.
 - A Youth Aware of Mental Health (YAM): A programme for 14-16 year olds promoting increased knowledge and discussion about mental health including the development of problem-solving skills and emotional intelligence. There are some implementation costs associated with introducing the program to a school including instructor training (conducted overseas) and course materials. For more information see www.y-a-m.org
-

School-based screening tools

- F Patient Health Questionnaire (PHQ-9): The 9 item PHQ-9 has been strongly supported for its applicability as a screening tool for adolescent depression in primary care as well as in paediatric hospital settings. The PHQ-9 takes approximately 5 to 10 minutes to complete. The optimal PHQ-9 cut-off score for adolescents is 11 or higher. The questionnaire is freely available from www.phqscreeners.com/select-screener
 - F Youth Risk Behaviour Survey (YRBS): The five suicide items (questions 26-30) from the YRBS ask about sad feelings and suicidal behaviour over the past 12 months. The questions take less than 5 minutes to complete. The YRBS has been strongly supported as a tool to detect risky behaviour in youth. The questionnaire is freely available from www.cdc.gov > **Healthy Living > Adolescent & School Health > Data & Statistics > YRBSS > Questionnaires**
 - F Beck Youth Inventory – Depression (BYI-II Depression): This 20-item questionnaire allows for early identification of symptoms of depression. It is designed for children and adolescents aged 7-18 and takes approximately 5 to 10 minutes to complete. Pricing and order information can be found at www.pearsonclinical.com.au > **Products > Psychology and Education > Child Mental Health, Behaviour and Personality > Beck Youth Inventories of Emotional and Social Impairment – Second Edition (BYI-II) > Items & Pricing / Booklets / BYI-II Depression Inventory Booklets**
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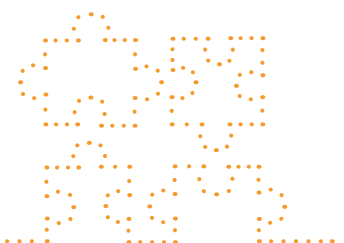
Aboriginal and Torres Strait Islander programs

Gatekeeper training

- E Aboriginal and Torres Strait Islander Mental Health First Aid: This course teaches members of the public how to assist an Aboriginal or Torres Strait Islander adult who is developing a mental health problem or in a mental health crisis. Mental health crisis situations covered include suicidal thoughts and behaviours, and deliberate self-harm. For more information go to www.mhfa.com.au > **Courses** > **Face-to-face** > **Aboriginal & Torres Strait Islanders**
- E Suicide Story: This DVD-based program was created by the Mental Health Association of Central Australia in partnership with Aboriginal and Torres Strait Islander people who live and work in remote communities. The program, which uses cultural practices, has been shown to increase knowledge and understanding of suicide as well as build confidence in responding to those at risk. For more information go to mhaca.org.au > **Education and Community Awareness** > **Aboriginal Suicide Prevention**

Community campaigns

- E LivingHope Bereavement Support: Developed by The Salvation Army this program offers online or group workshops for those who are bereaved by suicide. The program has been shown to raise awareness and increase knowledge and confidence in supporting those bereaved by suicide. For more information go to <http://suicideprevention.salvos.org.au> > **training** > **living hope bereavement support**
- C Standby Response Service: A community-based suicide postvention program that provides a coordinated response of support and assistance for people who have been bereaved through suicide. Pre-post evaluations show that the intervention reduces psychological distress and suicidal ideation and improves quality of life for those bereaved by suicide. For more information go to www.unitedsynergies.com.au > **How We Help** > **Affected By Suicide** > **StandBy Response Service**



Section 7 – Resources

The resources in this section are useful in supporting the nine strategies outlined in this document.

Media guidelines

- The Mindframe website is a resource to support the reporting and communication of suicide and mental health. The resource, *Reporting Suicide and Mental Illness*, developed by Australia's Department of Health and Ageing (2004) is available as a PDF to download at www.mindframe-media.info > **For media > media resources > Reporting Suicide and Mental Illness**
- *Preventing Suicide: A Resource for Media Professionals*, developed by the World Health Organization (2008) which is available at www.who.int/en > **Programmes > Mental Health > Suicide Prevention > Resource booklets > Preventing Suicide: A resource for media professionals [PDF]**
- The American based website www.ReportingOnSuicide.org provides recommendations for how to cover suicide reporting in the media. The guidelines can be downloaded from the **Reporting on Suicide homepage**.

School-based resources

These school resources provide the frameworks in which to position effective school based suicide prevention programs.

- KidsMatter: A flexible whole-school approach to children's mental health and wellbeing for primary schools. The program works on its own or as an umbrella under which a school's existing programs can comfortably fit. For more information visit www.kidsmatter.edu.au
- MindMatters: A mental health initiative for secondary schools that aims to improve the mental health and wellbeing of young people. It is a framework which provides structure, guidance, and support while enabling schools to build their own mental health strategy to suit their unique circumstances. For more information visit www.mindmatters.edu.au
- Headspace school support: An initiative that works with school communities to respond to and recover from the suicide of a student. A suicide postvention toolkit can be downloaded from the website and used by schools to assist them in responding to a suicide. More information can be found at www.headspace.org.au/schools

Community engagement

- Measuring community capacity resource kit: Flowchart showing the necessary steps to help gauge community readiness and capacity for change. To download the flowchart visit www.horizonscda.ca > **Services > Products & Resources > Resource Kit**
- Service finder: Provides access to suicide prevention and crisis support contact numbers from any location in Australia. To access the service finder go to www.wesleymission.org.au > **Our Services > Wesley Mental Health Services > Wesley Suicide Prevention Services > Suicide prevention – Wesley LifeForce Service Finder**
- Conversations Matter: A practical online resource to support safe and effective community discussions about suicide. Visit www.conversationsmatter.com.au
- Contacts list: Provides a list of suicide prevention contacts particularly targeted towards small towns and local communities. To view the list go to communitiesmatter.suicidepreventionaust.org > **Useful contacts**
- National helplines and websites: www.beyondblue.org.au > **Get support > National help lines and websites**
- Living Is For Everyone: Provides a range of suicide and self-harm prevention resources. Visit the website www.livingisforeveryone.com.au
- Partnerships analysis tool: A resource for establishing, developing and maintaining partnerships for health promotion. To download the PDF go to www.vichealth.vic.gov.au > **Media & Resources > Research & Publications** and search for 'Partnership analysis tool 2011'
- Wesley LifeForce community hub: Offers several templates to help foster process or implementation evaluations and assess community engagement www.wesleymission.org.au > **Our services > Wesley Mental Health Services > Wesley Suicide Prevention Services > Suicide prevention – Wesley LifeForce networks > Wesley LifeForce Community Hub**
- Resources that provide guidelines on how to include the voice of lived experience in suicide prevention include:
 - Suicide Prevention Australia are working on a project called the 'Lived Experience Network.' For information visit www.suicidepreventionaust.org > **projects > Lived Experience Network**
 - Download the Lived Experience Guidelines 2014 [PDF] www.suicidepreventionaust.org > **projects > Lived Experience Network > Lived Experience Symposium, June 2014**

- Resources that provides a list of mental health consumers and carer groups across Australia include:
 - Mental Health Australia: www.mhaustralia.org > Report > Media > National Register Mental Health Consumers and Carers
 - beyondblue: www.beyondblue.org.au > Get involved > blueVoices
 - National Mental Health Consumer & Carer Forum: www.nmhccf.org.au

Aboriginal and Torres Strait Islander suicide prevention

- The second edition of the *Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice* book (edited by Dudgeon, Walker and Milroy): A Commonwealth Department of Health-commissioned resource intended for all working in areas that support Aboriginal and Torres Strait Islander mental health and wellbeing. It contains a chapter on suicide prevention. The text is available free of charge at: aboriginal.telethonkids.org.au > Kulunga Research Network > Working Together 2nd Edition 2014
- The National Empowerment Project (NEP): An example of effective Aboriginal and Torres Strait Islander community engagement. The NEP aims to enhance the capability and capacity of local Aboriginal and Torres Strait Islander communities to take charge of their lives and address the range of social determinants that impact upon their cultural, social and emotional wellbeing. One anticipated outcome is reductions in suicide. See: www.nationalempowermentproject.org.au > Background
- The *Elders' Report into Preventing Indigenous Self-harm & Youth Suicide*: The report was produced in response to the significant increase in Aboriginal and Torres Strait Islander young persons' self-harm and suicide over the past 20 years across Australia's Top End. It describes, through the voices of Elders, efforts to reduce suicide in these communities. See: www.cultureislife.org > Elder's Report
- The Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project: The project aims to develop a community tool for the evaluation and development of Aboriginal and Torres Strait Islander suicide prevention programs and services, including processes for developing services. This should be published online in 2016. The resource will also include a mapping tool showing rates of Aboriginal and Torres Strait Islander suicide across Australia over time by postcode. See: www.atsispep.sis.uwa.edu.au
- The 2015 *Gayaa Dhuwi (Proud Spirit) Declaration*: Developed by the National Aboriginal and Torres Strait Islander Leadership in Mental Health (NATSILMH) to promote Aboriginal and Torres Strait Islander leadership across relevant parts of the mental health system for better Aboriginal and Torres Strait Islander mental health and suicide outcomes. See: www.natsilmh.org.au
- The *Closing the Gap Clearinghouse – Engagement with Indigenous communities in key sectors (2013)*: This paper provides a review of successful engagement models with Aboriginal and Torres Strait Islander communities. See: www.aihw.gov.au > Closing the Gap > Publications > 2013 > Engagement with Indigenous communities in key sectors (October 2013)
- National Mental Health Commission, *Contributing lives, thriving communities, Specific challenges for Aboriginal and Torres Strait Islander people – A summary from the Report of the National Review of Mental Health Programmes and Services*, NMHC, 2015; available online at: www.mentalhealthcommission.gov.au > Our Reports > Contributing Lives, Thriving Communities – Review of Mental Health Programmes and Services > Specific challenges for Aboriginal and Torres Strait Islander people [PDF]
- *National Aboriginal and Torres Strait Islander Suicide Prevention Strategy*: The aim of this document is to reduce the cause, prevalence, and impact of suicide on Aboriginal and Torres Strait Islander peoples, their families and communities. The document encompasses the Aboriginal and Torres Strait Islander holistic view of health including mental, physical, cultural and spiritual health. See: www.health.gov.au > For consumers > Education and prevention > Mental Health > National Aboriginal and Torres Strait Islander suicide prevention strategy

LGBTI inclusivity training and resources

- ACON provides a wide range of training and consultancy services to assist with all aspects of LGBTI inclusion. They are Australia's largest and most recognised national provider for LGBTI inclusion, operating across all states. ACON have a range of solutions to suit organisations of any size, spanning government, healthcare and service providers, large employers, small business, and sporting and community groups. More information can be found at www.acontraining.org.au
- MindOUT!: The National LGBTI mental health and suicide prevention project helps mainstream mental health and suicide prevention organisations to be more responsive to the needs of LGBTI people and communities. MindOUT! also supports LGBTI people and communities to better identify and respond to their mental health needs. More information can be found at lgbtihealth.org.au/mindout
- Recommended data collection indicators to identify LBGTI populations can be found online at www.acon.org.au > Policy & Research > Research > Recommended Sexuality and Gender Indicators



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Appendix A: Risk factors

Suicidal behaviour results from complex interactions between many risk factors across an individual's life span. A history of a suicide attempt is one of the major risk factors for suicide.¹⁵ Individuals attempting or dying by suicide often experience multiple stressors and negative life events in the months prior to their attempt or death. These stressors can include interpersonal conflicts, relationship breakdown, bereavement, physical illness, unemployment, job problems, financial problems, domestic violence, serious injury or assault, racism and other forms of discrimination including experiences of homophobia or transphobia.

Loneliness and isolation may lead to depression and emotional distress or increase their severity, as well as exacerbate the effects of negative stressors. According to the interpersonal theory of suicide,⁹⁰ a feeling of being a burden to others and a feeling of loneliness accompanied by an acquired capacity for suicide, such as lowered fear of death and increased tolerance for physical pain, are common experiences of individuals at-risk of suicide.

Table 4.

Suicide risk factors at an individual and social level

Risk factors	
Individual level	Socio-cultural or situational level
<ul style="list-style-type: none">• Gender (male)• Family history of suicidal behaviour• Mental illness: mood disorders such as depression and anxiety, schizophrenia and other psychotic disorders, and substance-use disorders• Previous history of suicidal behaviour• Childhood trauma• Low coping potential• Hopelessness• Aggression and impulsivity• Worry and rumination• Psychological pain• Chronic pain• Neurobiological and genetic factors• Marital status: divorce, widowed, separated• Experiences of homophobic/transphobic abuse/violence	<ul style="list-style-type: none">• Indigenous status• Exposure to suicidal behaviours through sensationalist reporting by the media• Access to and availability of lethal means of suicide• Unemployment or financial crisis• Stressful life events• Relationship breakdown• Poor social networks• Social isolation, lack of social support• Imprisonment and release from prison• Bereavement• Homelessness• Academic difficulties• Domestic violence

Glossary of terms

Attachment-based family therapy (ABFT)

Relationships with family members can exacerbate or buffer against adolescent depression and suicide. ABFT aims to repair relationship ruptures and rebuild safe and secure parent-child relationships with the end goal of promoting adolescent autonomy.

Cognitive behaviour therapy (CBT)

A talk therapy that assists individuals to identify unhelpful thoughts and behaviours and teaches them new skills and strategies for improved quality of life. Cognitive therapy for suicide prevention is a specific intervention designed to prevent repeat attempts.

Dialectical behaviour therapy (DBT)

A skills based therapy that teaches individuals how to: identify thoughts that make life harder, manage their emotions including tolerating emotional pain in difficult situations, practice mindful awareness, and have healthy relationships with others. The original form of DBT involved individual and group therapy with telephone coaching from a therapist supported by a consultation team. Modified versions of individual or group therapy are now widely used.

Help-seeking

The process of actively seeking help or support in order to improve a situation or problem. This involves the ability to recognise and verbally express symptoms or problems, an understanding of where and how to get support, and a willingness to disclose internal states.

Lived experience

Individuals who have first-hand knowledge or experience of living with suicide behaviours and consequences. This may be personal experience with relation to the self, or through caring for others.

Mental health literacy

Knowledge and beliefs about mental disorders that help individuals to recognise, manage, or prevent mental illness. This may include knowledge pertaining to prevention of onset, recognising signs and symptoms, causes and risk factors, management and treatment, and sources of help. This knowledge may aid an individual themselves or someone within their social network.

Pharmacotherapy

The use of pharmaceutical drugs in the treatment of psychological disorders and symptoms.

Postvention

An intervention conducted after a suicide has occurred and usually targeting those bereaved by the suicide including family, friends, professionals, community members, colleagues, and peers. These individuals may be at increased risk of suicide themselves. Postvention aims to increase resilience and help them cope with the loss.

Problem solving therapy

A psychological treatment that helps individuals improve their ability to cope with stressful life experiences. Individuals are assisted in understanding the role of thoughts and emotions, and then guided to develop an action plan to solve identified problems.

Psychodynamic interpersonal psychotherapy

A brief psychological treatment which aims to give people a better understanding of their problem so they can be better managed. This is achieved through several means including focusing on emotions; identifying habitual and unhelpful patterns in thinking, feeling, and behaving; and exploring relationship difficulties.

Self-poisoning

An episode whereby an individual exposes themselves to a substance that has the potential to cause harm. Substances can be ingested or inhaled. The episode may be accidental or deliberate and can lead to a fatal or non-fatal outcome.

Suicidal ideation

Also referred to as suicidal thoughts and may indicate a preoccupation with suicide. Suicidal thoughts can range from fleeting to pervasive and all consuming.

