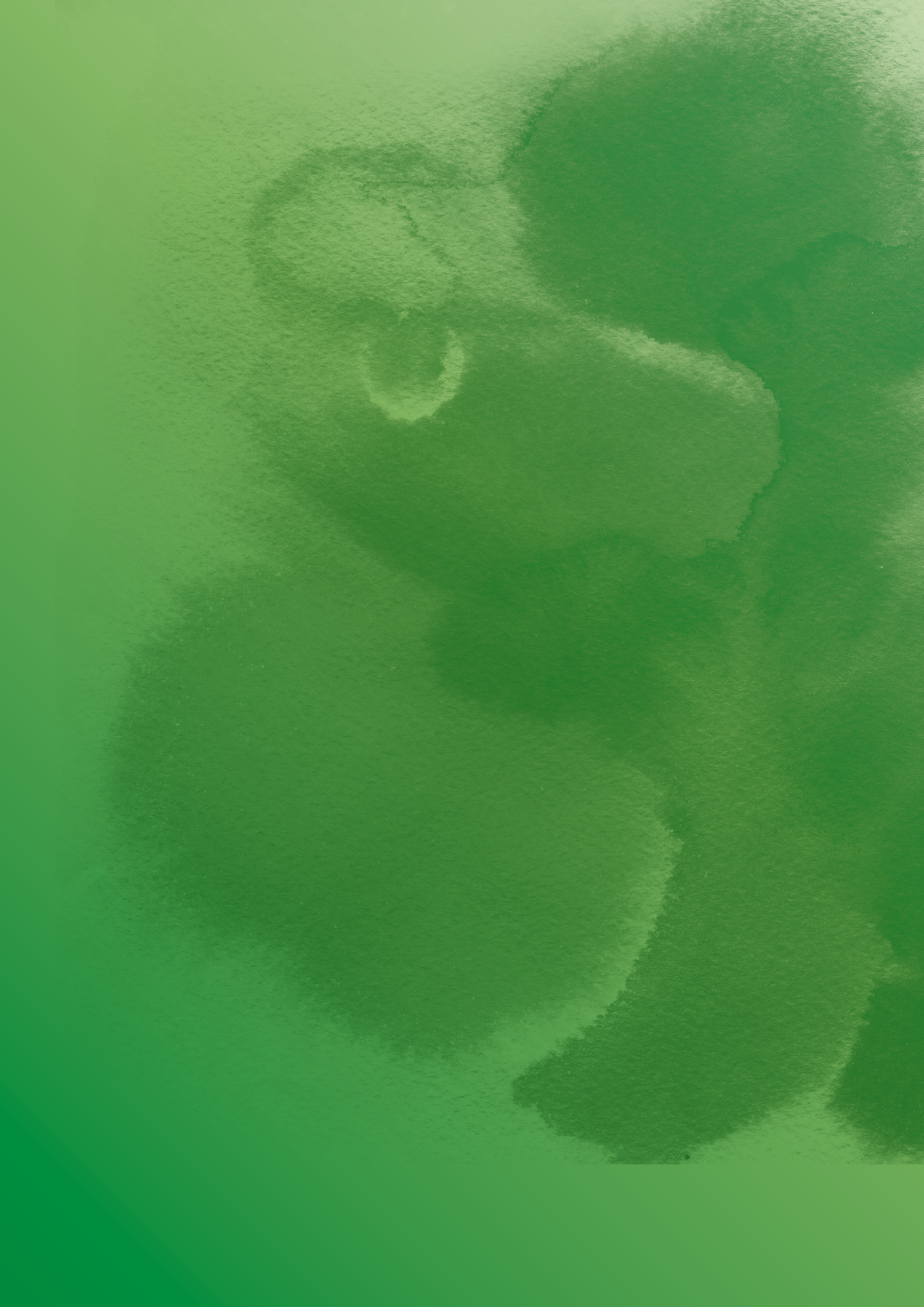
Government of **Western Australia**
Mental Health Commission

SUICIDE PREVENTION 2020

TOGETHER WE CAN SAVE LIVES

onelife



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MINISTER'S FOREWORD

Hon Helen Morton MLC

On average one person loses their life to suicide every day in Western Australia. The impact of this statistic is felt deeply and spans the entire community.

Preventing suicide and suicidal behaviour is a key priority for the Government of Western Australia, which launched the first statewide Suicide Prevention Strategy in 2009. *The Western Australian Suicide Prevention Strategy 2009 – 2013* achieved significant community engagement. Much good work was done, with greater community awareness, training and resilience achieved through local community activities and workplace partnerships.

It is a fact that in Western Australia the suicide rate exceeds the road toll. In much the same way that I believe every death on our roads can be avoided, I also believe that suicide is preventable. While I acknowledge that it is unlikely we can achieve a zero rate of suicide in my lifetime – just as it is unlikely that there will be no fatalities on our roads – it is something we need to strive towards.

Suicide Prevention 2020: Together we can save lives aims to halve the number of suicides in ten years, which is aligned with the National Coalition for Suicide Prevention. The new strategy takes an evidence-based approach to reduce suicide risk across the lifespan, which reflects current research by the World Health Organization.

The biggest risk factor for suicide and self-harm is having a mental illness and a previous suicide attempt. Young people, Aboriginal people and people who use alcohol or other drugs are also at greater risk of suicide than the general population. Targeting these groups through specific initiatives, as well as intervening early and at key stages throughout the lifespan is imperative to effective suicide prevention. To address the multitude of

social determinants including the reduction of violence, dysfunction, homelessness and poverty, *Suicide Prevention 2020* will deliver initiatives that foster resilience and strengthen families to improve mental health and reduce the suicide rate in the long term.

A key feature of *Suicide Prevention 2020* is its emphasis on evidence-based training for community facilitators who are often the first point of contact for mental health problems and suicide. Community facilitators include coaches, teachers, chaplains, general practitioners, aged care workers and child health nurses, and local community leaders. Training community facilitators to become 'gatekeepers' will help to disseminate information on depression and suicide risk, support early intervention and ensure pathways to professional support.

The previous One Life partnerships to promote suicide prevention among workplaces will be strengthened. Employers can play a significant role in improving the mental wellbeing of their staff by providing mental health and suicide prevention training; and creating a supportive environment which enables people to fulfill their potential and cope with life's challenges.

The State Government is working to improve mental health services, including systemic and legislative change, and structural reform. The merger of the Mental Health Commission with the Drug and Alcohol Office will seek to address some of the issues around co-occurring mental health and substance use problems that have been demonstrated to increase the risk of suicide. Improving access to services and supports, increasing workforce capacity and systemic change, will be addressed through the implementation of *The Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015 – 2025*.

The prevention of suicide is not something that can be achieved by one organisation in isolation – it is something that must be tackled by the entire community. *Suicide Prevention 2020* provides the framework and governance structure for suicide prevention in Western Australia. However, it is up to individuals, community, government and business to implement the changes and directions needed to create lasting change. Suicide is preventable, together we can save lives.

Hon Helen Morton MLC
Minister for Mental Health


IN
WESTERN
AUSTRALIA
1
PERSON DIED EVERY
DAY BY SUICIDE
IN 2012 –
A TOTAL OF
366
PEOPLE

CALL TO ACTION FROM THE MINISTERIAL COUNCIL FOR SUICIDE PREVENTION

Dr Neale Fong, Chairman

Our vision is that by 2025 we will have the services, supports and community capacity to achieve a 50% reduction in the current number of suicides and suicide attempts in Western Australia.[1]

We believe that every life is valuable and suicide is preventable. We urge everyone – family, friends, neighbours, schools, workplaces, communities and services – to work together to save lives.

While there has been significant investment and activity in suicide prevention across a range of communities, we remain deeply concerned about suicide rates in Western Australia. On average almost one person suicides every day in Western Australia.[1] In 2012, 366 people took their lives in communities across the State. These deaths mean we are forever robbed of the unique qualities and contribution of hundreds of Western Australians and families are forever bereaved.

For each adult death by suicide there are around 20 other people who have attempted suicide.[2] Continuing care and services for people who are suicidal need to be significantly improved. Everyone dealing with life's challenges – such as health issues, relationship problems, alcohol or other drugs, job and financial worries, or loneliness – should be able to access assistance to resolve problems and reconnect with the community.

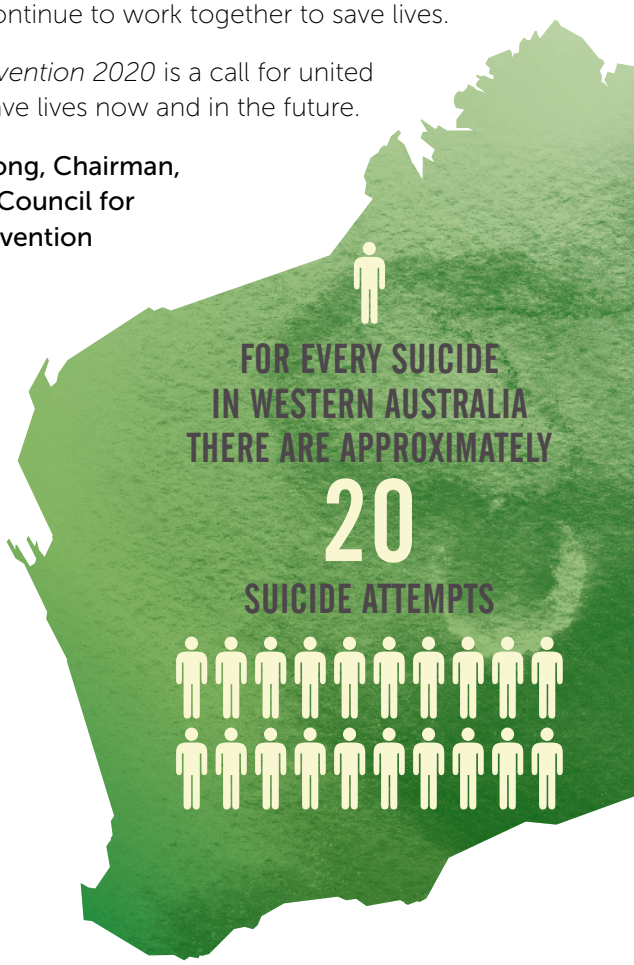
We are profoundly saddened by the current youth suicide rate. Suicide is the main cause of preventable deaths for 15 – 24 year olds in Western Australia. Research indicates that cumulative trauma from abuse and neglect can contribute to mental health issues that can result in self-harm or suicide.[3] Every child has the right to grow up in a healthy family and safe community, with opportunities to live a meaningful life, develop positive relationships and achieve their goals.

We mourn the unnecessary loss of life by suicide. For every suicide death there are many family members, friends and colleagues experiencing immense grief, loss and sadness. We know that these people are then at higher risk of dying by suicide themselves. Responsive services, understanding and compassion are essential to support people who have lost loved ones to suicide.

This extent of loss and trauma cannot continue. We must continue to work together to save lives.

Suicide Prevention 2020 is a call for united action to save lives now and in the future.

Dr Neale Fong, Chairman,
Ministerial Council for
Suicide Prevention



1 *The reduction rate will be relative to the 366 deaths by suicide recorded by the Australian Bureau of Statistics in Western Australia in 2012.*

INTRODUCTION

Suicide prevention is a major public health issue. The suicide rates in Western Australia are among the highest in the nation, with 13.5 deaths per 100,000 population in 2008-2012.[4] In Australia, suicide deaths result in an average loss of 34 years of life per person.[4] Every life lost to suicide is one too many; we must all work together to prevent these tragic deaths.

Suicide Prevention 2020: Together we can save lives (Suicide Prevention 2020) provides a strategy for prevention based on suicide statistics in Western Australia, contributing factors to suicide across life stages and evidence-based prevention and intervention approaches. It was developed utilising current data, research, evaluation and reports on *The Western Australian Suicide Prevention Strategy 2009-2013* and the expertise of members of the Ministerial Council for Suicide Prevention, some of whom have lost loved ones to suicide.

This new suicide prevention strategy builds on the State Government's continuing commitment to improve the mental health and wellbeing of the community, evidenced by the creation of the Mental Health Commission; the new *Mental Health Act 2014*; the establishment of the Statewide Specialist Aboriginal Mental Health Service; implementation of recommendations in the 2012 *Review of the admission or referral to and the discharge and transfer practices of public mental health facilities/services in Western Australia* by Professor Bryant Stokes; and other key initiatives as detailed in Appendix A.

In addition, *Suicide Prevention 2020* actions respond to key recommendations of important reviews such as:

- Auditor General (2014), *The Implementation and Initial Outcomes of the Suicide Prevention Strategy* (Auditor General's Report);
- Ombudsman Western Australia (2014), *Report on investigation into ways that State government departments and authorities can prevent or reduce suicide by young people* (Ombudsman's Investigation); and
- Centrecare and Edith Cowan University (2014), *Research, Development and Evaluation of the State Suicide Prevention Strategy 2009-13* (Strategy Research, Evaluation and Development Report).

Suicide Prevention 2020 continues to be informed by the Living is for Everyone Framework (LIFE Framework) and the *National Aboriginal and Torres Strait Islander Suicide Prevention Strategy (2013),* but has been updated to align with the World Health Organization directions outlined in *Public Health Action for the Prevention of Suicide: A Framework (2012); Preventing Suicide: A global imperative (2014)*; and *Social Determinants of Mental Health (2014)*. It is proposed that a coordinated range of activities will be delivered through collaborative partnerships, local community prevention programs and integrated services. The key outcomes and action areas are linked to the prevention priorities in *The Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015 – 2025*.

Since 2009, the State Government has invested $21 million in suicide prevention across the State. This includes significant funding for Community Action Plans and suicide prevention, crisis counselling and postvention services such as Lifeline and Youth Focus. There is much more to be done and *Suicide Prevention 2020* seeks to balance investment in community awareness and stigma reduction, mental health and suicide prevention training and coordinated services for high-risk groups. The strategy's successful implementation requires both financial and human resources, along with commitment to a shared vision and collaboration at many levels.

A KPMG Report *The economic cost of suicide in Australia* highlights the high cost to our economy from lives cut short by suicide. More people died by suicide in 2012 than from skin cancer or car crashes, and the majority were men aged 15-44. The economic cost of these deaths is estimated by KPMG at $1.657 billion and far exceeds investment in suicide prevention.[5]

However, suicide is not just a mental health issue. It is a public health issue that requires coordinated and combined efforts from all levels of government, health care systems, clinicians, workplaces, education and corporate sectors, community groups, insurers and the media; along with family, friends and peer networks.[6] It is envisaged that these diverse stakeholders will be able to adapt the priority action areas outlined in this strategy to effectively meet the needs of their communities, employees, members and networks.

Suicide Prevention 2020 outlines key partners and priority action areas for suicide prevention in Western Australia. The development of these focus areas has been informed by the Ministerial Council for Suicide Prevention, evaluation and reviews of the previous *Western Australian Suicide Prevention Strategy 2009-2013*, current suicide data and comprehensive research undertaken by the Mental Health Commission.

Our target groups for united action to prevent suicides are:

- People with a history of mental illness and their families;
- High-risk groups in the community;
- People bereaved by suicide;
- Local communities;
- Key decision makers across business, government and community organisations;
- Schools, education and training sectors;
- Providers of health services; and
- Media and opinion leaders.

Our work together can achieve:

1. Greater public awareness and united action across the community;
2. Local support and community prevention across the lifespan;
3. Coordinated and targeted responses for high-risk groups;
4. Shared responsibility across government, private and non-government sectors to build mentally healthy workplaces;
5. Increased suicide prevention training; and
6. Timely data and evidence to improve responses and services.

SUICIDE PREVENTION 2020 ACTION AREAS AT A GLANCE

1. Greater public awareness and united action

This action area will be achieved through:

1.1 Implementing a comprehensive communications strategy, including multimedia resources and media partnerships.

1.2 Delivering a comprehensive public education campaign and resources tailored to specific age groups and populations.

1.3 Promoting the use of mental health, counselling, alcohol and other drugs services, and reducing stigma and discrimination against people using these services.

1.4 Facilitating events to create community dialogue and inspire action.

1.5 Profiling the stories of bereaved families to create understanding and empathy, and reduce stigma around seeking help.

1.6 Providing opportunities for people with lived experience to share their stories to reduce stigma around accessing services.

2. Local support and community prevention across the lifespan

This action area will be achieved through:

2.1 Promoting and supporting evidence based and culturally informed mental health literacy programs.

2.2 Strengthening community based suicide prevention activities, local capacity building and leadership.

2.3 Collaborating with local stakeholders to strengthen suicide prevention protocols, establish ways to reduce access to means of suicide and map pathways to care to appropriate services and support.

2.4 Partnering with primary care providers to address mental health needs and risk factors.

2.5 Ensuring communities have the capacity to respond to crises and can access emergency services, crisis support and helplines.

2.6 Improving postvention responses and care for those affected by suicide and suicide attempts.

3. Coordinated and targeted services for high-risk groups

This action area will be achieved through:

3.1 Facilitating effective interagency coordination to address social determinants for suicide prevention across the lifespan.

3.2 Co-producing new programs with the at-risk groups themselves, including people with lived experience, family members and carers.

3.3 Delivering responsive, high-quality treatment and support for those with mental illness, aligned with the *Mental Health and Alcohol and Other Drug Services Plan 2015-2025*.

3.4 Improving policies, protocols, discharge planning and continuing care for people who have self-harmed and/or attempted suicide.

3.5 Strengthening early intervention services and family counselling to prevent and address cumulative trauma in children and young people.

3.6 Supporting interagency postvention responses for individuals and communities who have lost someone to suicide.

4. Shared responsibility across government, private and non-government sectors to build mentally healthy workplaces

This action area will be achieved through:

4.1 Assisting organisations to fulfil their responsibilities and legal obligations for the mental wellbeing and safety of their employees.

4.2 Developing implementation, monitoring and accreditation systems for workplace mental health and suicide prevention initiatives.

4.3 Setting minimum requirements for mentally healthy workplaces, including training to identify and support people at risk.

4.4 Acknowledging and disseminating best practice approaches to creating a mentally healthy workplace.

4.5 Encouraging large government and corporate organisations to have mental health and suicide prevention as a key outcome measure with adequate resources and monitoring.

5. Increased suicide prevention training

This action area will be achieved through:

5.1 Promoting training and self-help activities for high-risk groups, and peer support.

5.2 Supporting mental health and suicide prevention training in schools, vocational and tertiary education sectors and community groups.

5.3 Coordinating Gatekeeper and other programs for professionals and para-professionals including General Practitioners, health workers and frontline service providers.

5.4 Embedding trauma informed practice in the mental health workforce.

5.5 Backing up training with adequate supervision and de-briefing mechanisms.

6. Timely data and evidence to improve responses and services

This action area will be achieved through:

6.1 Collating, analysing and disseminating the latest research and evaluation reports on risk and protective factors and evidence-based programs.

6.2 Monitoring and evaluating initiatives for ongoing improvement.

6.3 Establishing a taskforce to monitor, improve and utilise suicide related data to inform planning, intervention and postvention responses.

KEY PRINCIPLES

Best-practice principles have guided the development of *Suicide Prevention 2020* and its associated action areas, specifically the World Health Organization *Social Determinants of Mental Health (2014)*; the Australian lived experience guiding principles (2014) drafted by Suicide Prevention Australia's advisory committee and endorsed by the National Coalition for Suicide Prevention; and the Western Australian strategic mental health policy *Mental Health 2020: Making it personal and everybody's business (2010)* [7, 8]. Throughout the implementation phase the principles below will continue to underpin decision making and initiatives under the priority action areas.

1. Valuing and including people with lived experience

People with a lived experience, including those who have attempted suicide, bereaved by suicide or affected by suicide, have a valuable, unique and legitimate role in suicide prevention. Lived experience helps change the culture surrounding suicide by creating empathy and understanding. People with lived experience will be supported to share their insights and stories with a view to preventing suicide. All suicide prevention programs, policies, strategies and services will, at all levels, include genuine meaningful participation from those with lived experience.

2. Action across sectors

Risk and protective factors for mental health operate at an individual, family, community, structural and population level. A social determinants approach will be led by the mental health sector; however it requires action, collaboration and leadership from education, primary care, social services, employment, justice and housing sectors at all levels.

3. Life course approach

Taking a life course perspective recognises that mental health is influenced by unique and common factors at each stage of life, and these factors accumulate throughout life. A life-course approach also seeks to address the intergenerational transfer of inequality, by improving conditions for future generations.[8] Organisations in which people are involved at different stages of life are the most appropriate to deliver appropriate interventions – such as early year settings, schools, family services, employers and seniors groups.

4. Early intervention

There is a strong evidence base and scientific consensus that giving every child the best possible start in life will generate the greatest societal and mental health benefits.[8] Actions should support parents and early childhood development; and enable children and adolescents to maximise their potential to create a mentally healthy adulthood.

5. Tailoring for diversity

The unique needs and circumstances of people from diverse backgrounds are acknowledged, including people from Aboriginal or from culturally and linguistically diverse (CaLD) backgrounds, people with disability or chronic illness and people of diverse sexual and gender orientation. Responsive approaches will be co-produced with high-risk groups to appropriately meet their needs.

6. Allocating resources where they are most needed and in a coordinated way

Actions and interventions to prevent suicide and self-harm will support the whole population, with targeted responses and appropriate resources for high-risk groups. State funded public mental health services treat individuals with severe mental health issues. However, the State will advocate for other parts of the system, including community managed organisations and primary health care, to deliver the full continuum of suicide prevention interventions.

7. Prioritising mental health and suicide prevention

Increased awareness and understanding of mental health and suicide prevention should coincide with appropriate direction of resources towards tackling mental illness, recognising that there are significant cost benefits in investing in mental health and suicide prevention.

8. Long term and sustainable approaches

Improving mental health across the life-course requires long term and sustained policies and actions that focus on reducing inequalities in health through community development, and strengthening local leadership and collaboration.

9. Knowledge for action at the local level

Systems and processes to gather and provide information must be built to support local actions. Information helps to identify, understand and respond to mental health risks at a regional level; build knowledge of local resources and services, and evidence-based interventions; assess impacts of local initiatives; and support regional interagency collaboration to prevent suicide.

10. Quality and best practice

Suicide prevention programs are informed by evidence of outcomes being achieved and contemporary best practice; easily accessed; and delivered in a timely and collaborative way.

[2] *Co-production ensures the general public (the receivers of services) and government (the providers of services) work together to achieve common goals of increased awareness about mental health, suicide prevention and services available to access help. Co-production includes community consultation and mutual responsibility to achieve goals. It aligns with strategic directions in* Mental Health 2020.

UNDERSTANDING THE PROBLEM OF SUICIDE

Current data on suicide

Suicide results in an average loss of 34 years of life per person. This compares with average years of life lost through deaths from heart disease (4 years) and cancer (8 years).[3]

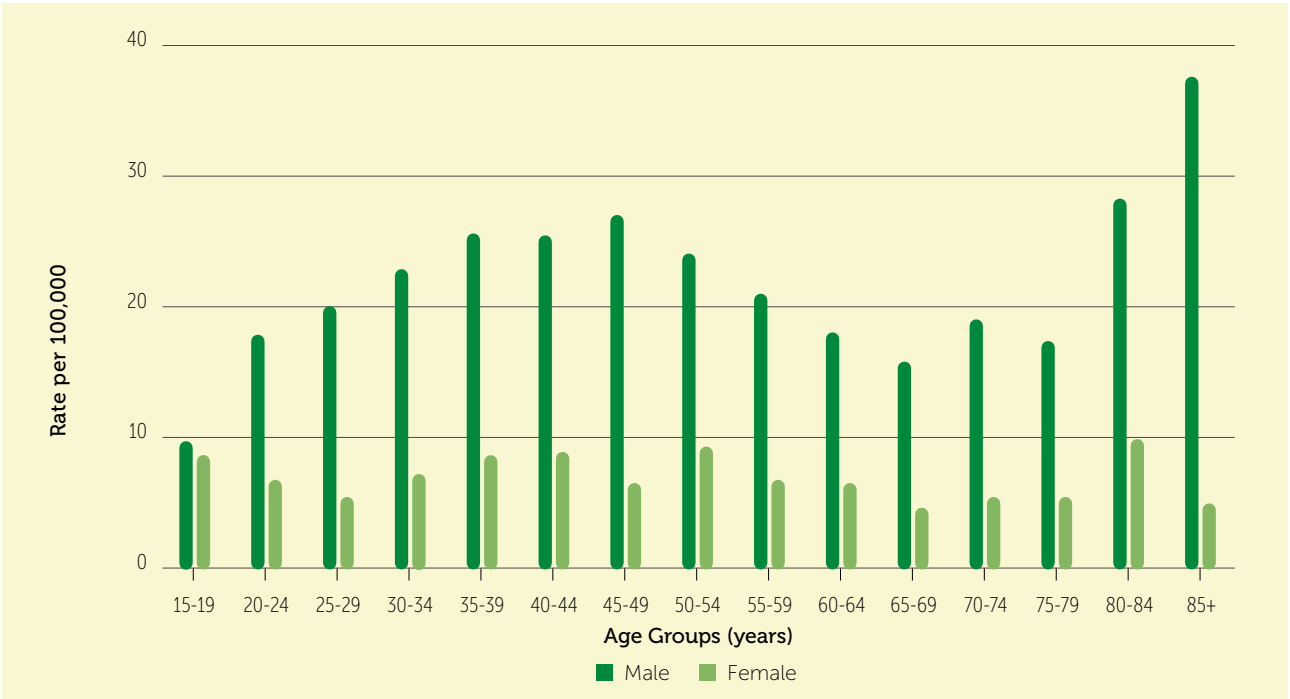
It is estimated that for every person who dies by suicide 20 people will attempt to take their own life.[2]

This tragic loss of life affects families, friends, colleagues and peers. For every death by suicide, there are around six people experiencing intense grief, which may continue for many years.[9]

How many people die by suicide each year?

- Worldwide an estimated 804,000 suicide deaths occurred in 2012 (11.4 per 100,000 population).[2]
- Approximately seven Australians die by suicide every day (10.8 per 100,000 in 2008-2012), with 2,535 suicide deaths in 2012.[9]
- Suicide is the leading cause of death for 15 to 44 year olds in Australia.[4]
- Men account for three-quarters of all suicide deaths; however, the suicide rate among women has been increasing.[4]
- In Western Australia, the suicide rate for Aboriginal and Torres Strait Islander people is almost three times higher than the non-Aboriginal population (39.1 per 100,000 in 2008-2012).

Figure 1. Age-specific suicide death rates, Australia 2012



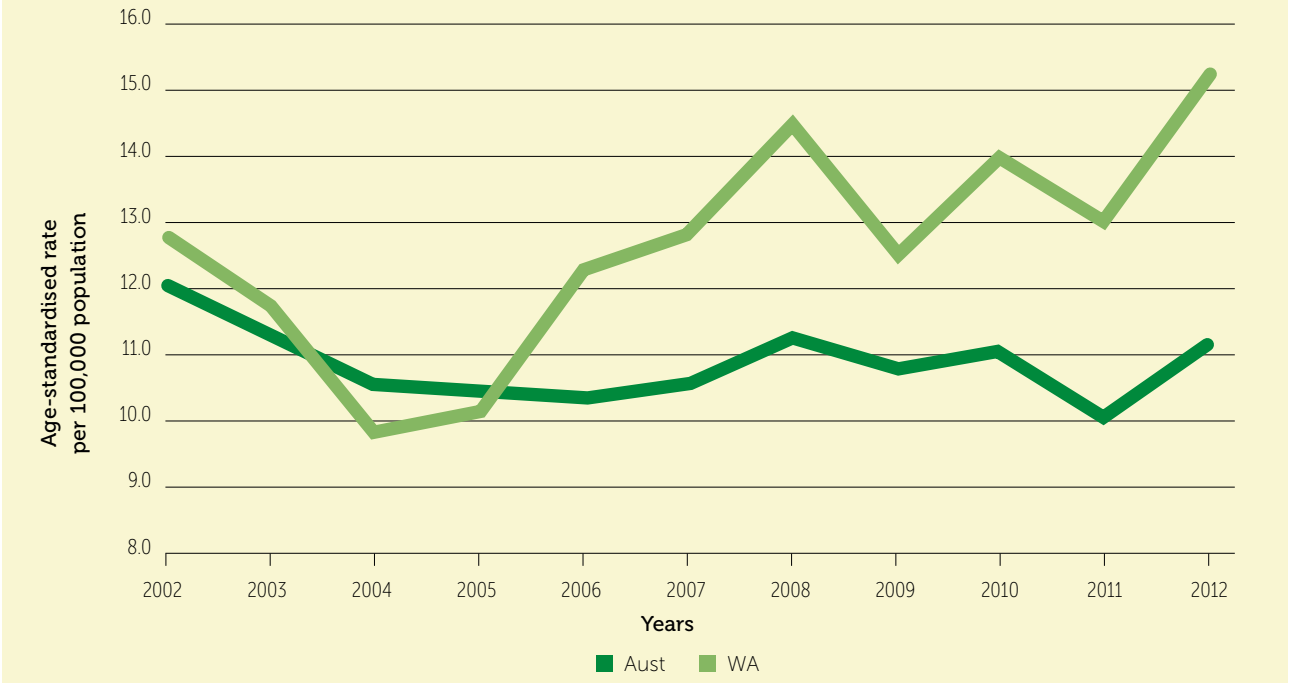
Source: Australian Bureau of Statistics, 2014

3 *Years of life lost are calculated for deaths of persons aged between 1 to 78 years.*
4 *Figures for 2012 are preliminary.*

Figure 2: Age-standardised rates of suicide by gender, Australia, 2003-2012

Source: Steering Committee for the Review of Government Service Provision, 2014

Figure 3. Suicide death rates, Western Australia and Australia, 2002-2012 [4]



Source: Steering Committee for the Review of Government Service Provision, 2014

What is the suicide rate in Western Australia?

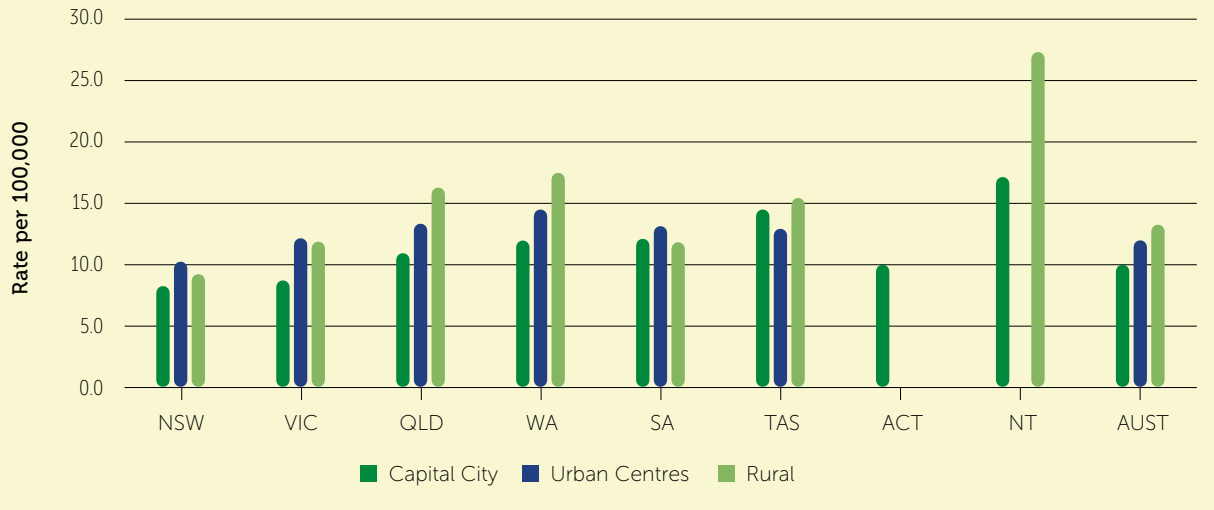
- In Western Australia the suicide rate has been considerably higher than the national rate since 2006, and reached 14.9 people per 100,000 in 2012. If the national rate was experienced in Western Australia this would translate to approximately 268 suicides based on Western Australia's population in 2012. While still too high, this is lower than the actual number (366) of suicides in Western Australia in 2012.
- Western Australia has higher suicide rates across all demographics and geographic regions, including the metropolitan area. The higher rates of suicide are particularly evident among Aboriginal and Torres Strait Islander People, and also in rural and remote areas.
- The reasons for Western Australia's high suicide rate are not yet fully understood and will be the subject of focused research during the implementation of *Suicide Prevention 2020*.

Table 1: Suicide by State and Territory, 2012

State	Males	Females	Persons	Rate per 100,000 2008-2012
New South Wales	512	195	707	8.9
Victoria	385	117	502	9.7
Queensland	472	149	621	13.0
South Australia	149	48	197	11.8
Western Australia	269	97	366	13.5
Tasmania	56	14	70	14.1
Northern Territory	41	7	48	18.1
Australian Capital Territory	17	7	24	9.1
Total	**1,901**	**634**	**2,535**	**10.8**

Source: Australian Bureau of Statistics, 2014

Figure 4. Suicide death rates by area, 2007-2011

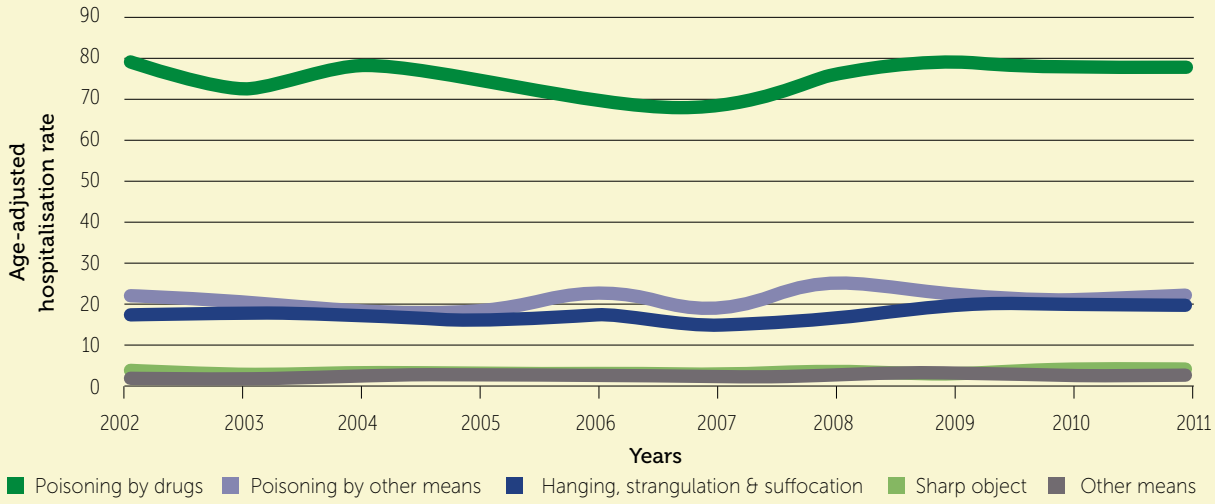


Source: Steering Committee for the Review of Government Service Provision, 2014

How many people attempt suicide and by what means?

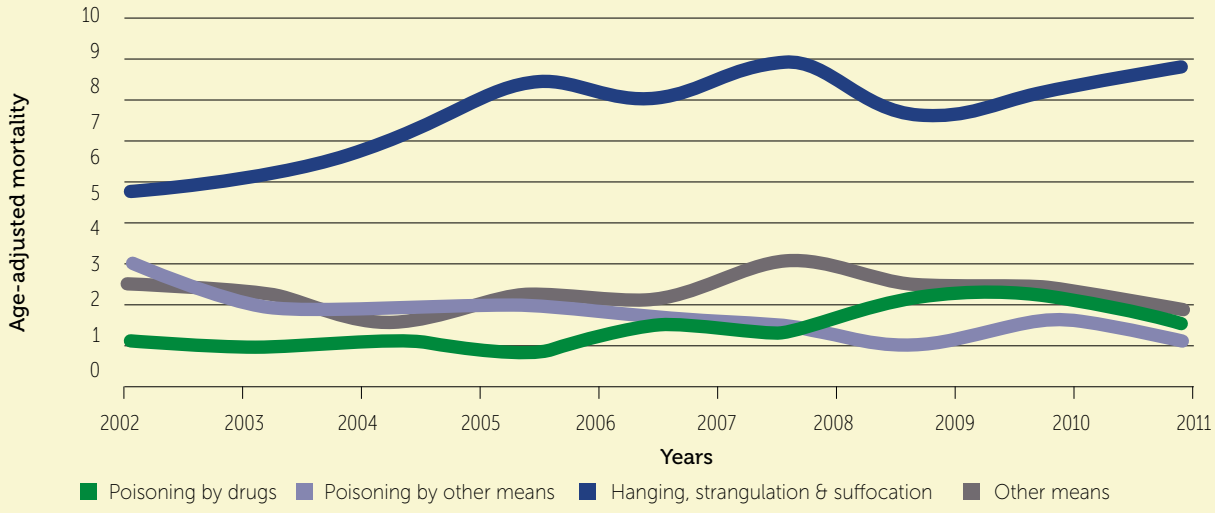
- It is estimated that each year 370,000 Australians think about ending their life and 65,000 suicide attempts occur.
- Limiting access to the means of suicide is one of the most effective approaches to suicide prevention.
- In Western Australia, suicide attempts from poisoning by drugs and poisoning by other means are a significant concern, highlighting the opportunity to reduce access to this means of suicide attempts and raising the need for integrated prevention strategies with alcohol and other drug services.

Figure 5: Hospitalisation in WA for suicide attempts, 2002-2011



Source: Department of Health Western Australia, Epidemiology Branch 2014

Figure 6. Deaths due to self-harm/suicide by cause and year WA, 2002-2011



Source: Department of Health Western Australia, Epidemiology Branch 2014

Major factors in suicide

Suicidal behaviour and mental illness

Suicidal behaviours can range from thinking about suicide, to making plans and then attempting suicide or in a worst case scenario, death by suicide. Suicidal behaviours are influenced by interacting psychological, social, environmental and situational factors.[11]

There are many factors associated with suicide. The strongest indicator of suicide risk is a previous attempt. Even a year after a person attempts suicide, they remain at high risk of suicide and premature death from other causes.[2, 12]

The most common and significant risk factor associated with suicide is mental illness. Previous Western Australian coronial data found that 35% of men and 60% of women who completed suicide had suffered from a diagnosed psychiatric disorder in the preceding 12 months. The observations of family and friends of those who completed suicide indicate that 57% of men and 66% of women exhibited symptoms of depression in the three months preceding their deaths. Over a third of Western Australian men who completed suicide between 1986 and 2005 had been admitted to a psychiatric hospital or a public hospital for psychiatric treatment at some time in their lives. Of these men, 15% completed suicide on the day of discharge from their last admission, whether they were an inpatient or on day-release. Similarly, one fifth of Western Australian women who died from suicide completed suicide on the day of discharge, and a third within a month of discharge.

More recent research highlights that mental illness is present in up to 90% of people who die by suicide in higher socio-economic countries.[2, 13] Conditions with the greatest risk of suicidal behaviour are major depression, bipolar disorder, anorexia nervosa, schizophrenia and borderline personality disorder.[14] It is estimated that around 80% of conditions are untreated at the time of the person's death.[15] People experiencing mental illness are also at higher risk of suicide after discharge from hospital or when treatment has been reduced.[16]

As suicide is closely linked with mental illness, historically suicide prevention is often regarded as an issue that mental health services and the public health system should address. However, caution is needed in viewing mental illness as the sole risk factor, as there are other critical risk and protective factors that must be considered. For example everyone has a role in reducing isolation and enhancing social connectedness for vulnerable people, and this is an important suicide prevention strategy.[6]

It should be noted that many people who experience mental illness do not display suicidal thoughts or behaviour.[2] Further, 45% of Australians will experience mental illness in their lifetime [17] and most people recover with appropriate support. In addition, a person does not need to have a mental illness for suicide risk to be present.[16]

Alcohol and other drugs

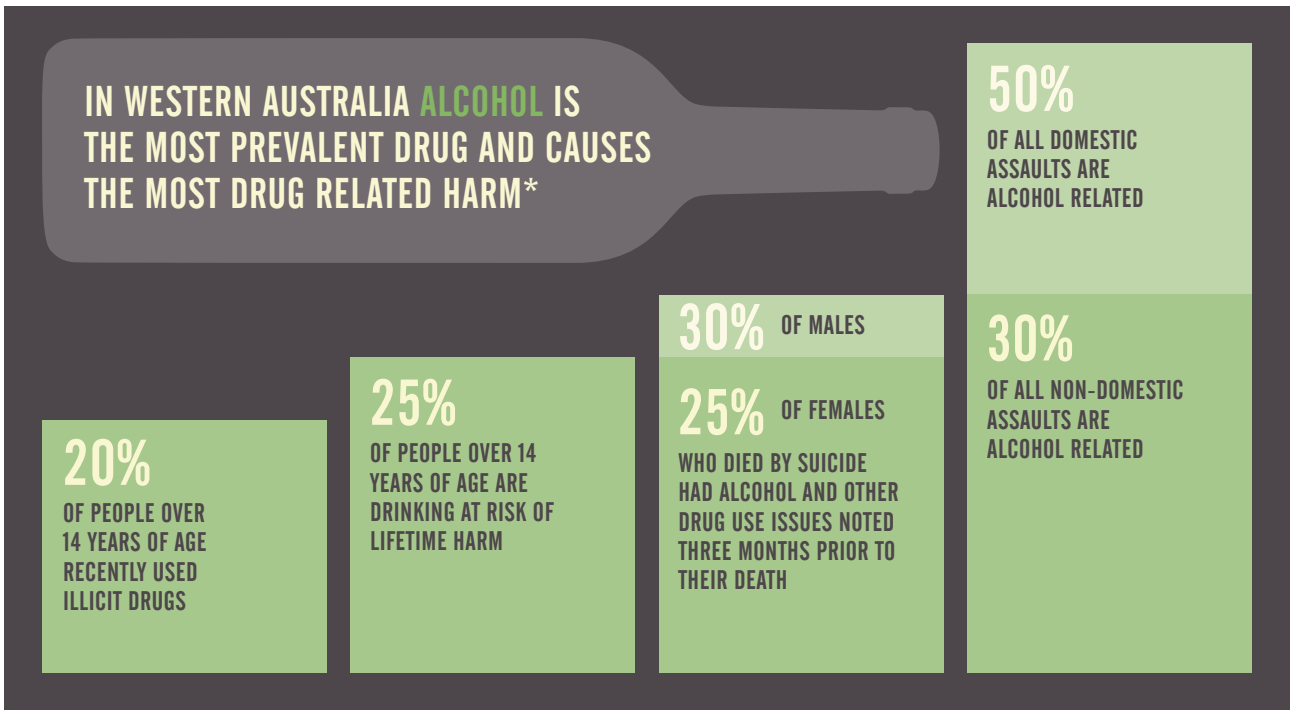
The harmful use of alcohol and other drugs compounds personal and social problems and detrimentally impacts on a person's mental health and wellbeing. Long-term use and/or dependency is associated with increasing stress that may trigger or intensify existing mental illness.[18] People with alcohol or other drug problems have a higher risk of dying by suicide than the general population.[19]

Research shows that suicide rates decreased by as much as 5% as alcohol consumption decreased by one litre per capita. The inverse is also true.[20] The relationship between alcohol and suicide in countries with a binge drinking culture is stronger than those without. [21] There is frequently an increase in alcohol and drug use in the period before suicide. Western Australian coronial data indicates that nearly a third of men and a quarter of women had substance abuse issues noted three months prior to their death.[18]

Alcohol also compounds other risk factors for suicide. In Western Australia, more than half of all domestic and over a third of all non-domestic assaults are alcohol related.[22]

The risk of suicide among illicit drug users is between four and 14 times that of the general population.[23] Cannabis users are estimated to have 10 times higher risk of suicide than non-users.[24]

Risk is exacerbated for people with co-occurring mental illness as services have historically not provided holistic treatment.[15] Studies on suicide linked to drug or alcohol dependence showed marked disengagement from services (e.g. missed appointments and self-discharge) prior to death. Services were less likely to follow-up or re-engage with these patients, possibly seeing them as difficult



* Excludes tobacco

to treat.[25] This highlights systemic barriers and stigma towards service users that needs to be addressed. Both suicide and alcohol and other drugs-related harm share common risk factors that can be targeted at a social level, and through integrated service delivery and systems.

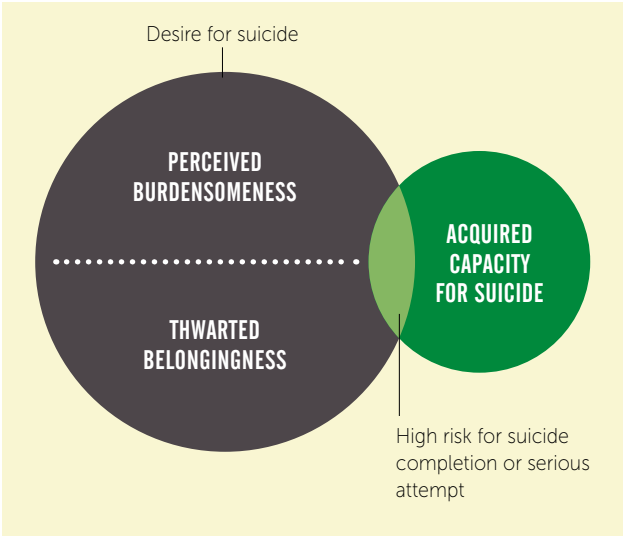
Interpersonal factors

More recently, researchers have examined interpersonal factors that diminish a person's natural instinct for self-preservation from death. A person becomes more vulnerable when they are socially isolated or feel they are a burden to others due to long term unemployment, chronic illness, homelessness or other difficulties.[26] Their suicide risk increases when this social disconnection is combined with fearlessness towards death (acquired capacity). Over the course of a lifetime, they may become less afraid of pain and death due to trauma and abuse; high-risk behaviours; injuries from contact sport or dangerous work; or familiarity with lethal means such as firearms or drugs.[26]

Addressing these intersecting issues requires quality mental health, alcohol and other drugs services and ongoing support; along with holistic approaches across the lifespan to address the interpersonal, social, psychological and situational issues contributing to mental illness, suicidal behaviours and preventable deaths.[15]

Other contributing aspects are an individual's access to lethal means of suicide; cultural and social factors including attitudes towards suicide; contagion effects or clustering of suicide; impulsive or aggressive behaviour; and an inability to deal with distressing emotions.

Figure 7: Intersection of desire for suicide and acquired capacity for suicide



Joiner, T. (2005) *Why People Die by Suicide*. Cambridge, MA: Harvard University Press

Vulnerability to suicide across life stages

Mental health, mental illnesses and suicidal behaviour are all shaped by intersecting biological, psychological, social, environmental and cultural factors.[2] The World Health Organization highlights that population health approaches should improve the conditions of daily life from before birth, during early childhood, at school age, during family building and working ages, and at older ages.[2] Addressing social inequalities and risk factors across these life stages is essential for effective early intervention and prevention.

Building resilience from suicide among the Western Australian population requires age and culturally appropriate activities; informal support through family members, carers and local communities; and a range of integrated services and across-government initiatives.

Family building and young children

There is great benefit in fostering family, community, education, health, recreation and workplace environments that support social inclusion and strong families. Families have a fundamental role in helping people to develop healthy relationships and resilience and are an underutilised resource for suicide prevention and early intervention.[27]

Suicide among children is a rare occurrence. However, the environments in which children are raised can sometimes transfer intergenerational disadvantage and risk.[8] Educating parents about mental health and the importance of seeking help early when problems arise in families is an investment in mental health that has benefits over the child's lifetime. It also has the potential to improve the mental health of future generations.

In our society women still have the primary caring role and being pregnant or having young children can be a protective factor against suicide.[28] However, higher risk is evident in mothers who experience distress or trauma related to postnatal depression; the death of a child; being apart from their children due to divorce, family separation or removal of children into protective care; or lack of support in caring for a child with mental illness.[28, 29] It is vital that family, partners and health workers know how to respond to signs of emotional distress, and professional assessment and support is accessed.[30]

Strengthening Western Australian families and building protective factors for mental health over their life course calls for a cross-government, multidisciplinary approach in conjunction with long-term planning for Australia's health and education systems. It also requires the capacity to support at-risk individuals and families in need; ranging from better screening and risk assessment through to evidence-based treatment options and follow-up care.

Adolescents and young people

In Western Australia suicide is the main cause of preventable death for adolescents. The 2014 State Ombudsman's investigation into suicide deaths of 36 young people aged 13-17 year old found that the majority had experienced trauma from physical and sexual abuse and/or neglect.[3] In this investigation, Aboriginal young people were found to be much more vulnerable. They made up 36% of suicide deaths, yet constitute only 6% of the youth population in Western Australia.[3]

The Ombudsman recommended that mental health literacy and suicide prevention education be continued, along with inter-agency collaboration to screen young people for multiple risk factors, establish joint case management approaches and provide longer term, ongoing treatment and support.[3] Further, recommendations to improve systemic responses were identified for the Departments of Child Protection and Family Support, Education and Health.

One in four young Australians aged 16-24 will experience a mental illness, and these young people are five times more likely to misuse drugs.[31] Considering all causes of death, suicide accounted for 21.9% of deaths among 15-19 year old males and 28.7% of deaths among 20-24 year old males in 2012. Of concern, the corresponding percentages for females in both of these age groups has been increasing and is 32.6% and 25.2% respectively.[4] This raises the need for greater research to understand contributing factors; age and gender specific programs to promote early help-seeking and peer support; and increased early intervention services.

Working age

Adults spend about a third of their waking hours at work. Workplaces have an important role to play in building protective factors for suicide among their staff, yet significant gaps exist in our understanding of the relationship between work and suicide.[32]

Most deaths by suicide in Australia are among people of working age. Suicide is the leading cause of death for males aged 25–44 years and females aged 25–34 years.[33]

The World Health Organization suggests worker suicide is the result of a complex interaction between individual vulnerabilities and work-related environmental factors that trigger stress reactions and contribute to poor mental wellbeing.[32]

Stressors within the workplace can have consequences for mental wellbeing, and mental illness should be given the same priority as that of physical illness and safety. Organisations across all sectors have a responsibility to build mentally healthy workplaces and to reduce stigma and discrimination surrounding suicide and mental illness. Having a supportive workplace and meaningful employment can assist people to recover from difficulties and strengthen protective factors to reduce suicide risks in the long term.

Employers have a legal responsibility to provide a safe and healthy workplace. Investing in mental health in the workplace also has significant cost-benefits for employers, as for every dollar spent there is an average return of investment of $2.30, and up to $5.70 in some industries. Untreated depression has been estimated to cost $12.3 billion a year.[34]

Contemporary Western Australian research into attitudes towards mental illness and reducing stigma found that 3 in 10 people would not disclose their mental illness in the workplace.[52] Those who suffer stigma associated with suicidal behaviour are vulnerable to similar consequences; experiencing real and perceived discrimination in terms of social inclusion and networks, income, and health opportunities.[52]

Recently in Western Australia there has been increased reporting of mental health problems, suicide risks and deaths in the mining and construction industry, where workers fly or drive long distances from their hometown to mine sites or remote locations on a cyclical basis. While these jobs pay well, they require long shifts and separation from family and friends, often for weeks at a time. Fly-In Fly-Out and Drive-In Drive-Out (FIFO and DIDO) workers are considered to be at greater risk of misusing alcohol and other drugs.[7] As most mining and construction workers are men, this workforce reflects the wider reality that suicide is the leading cause of death of Australian men aged 15-44.[4]

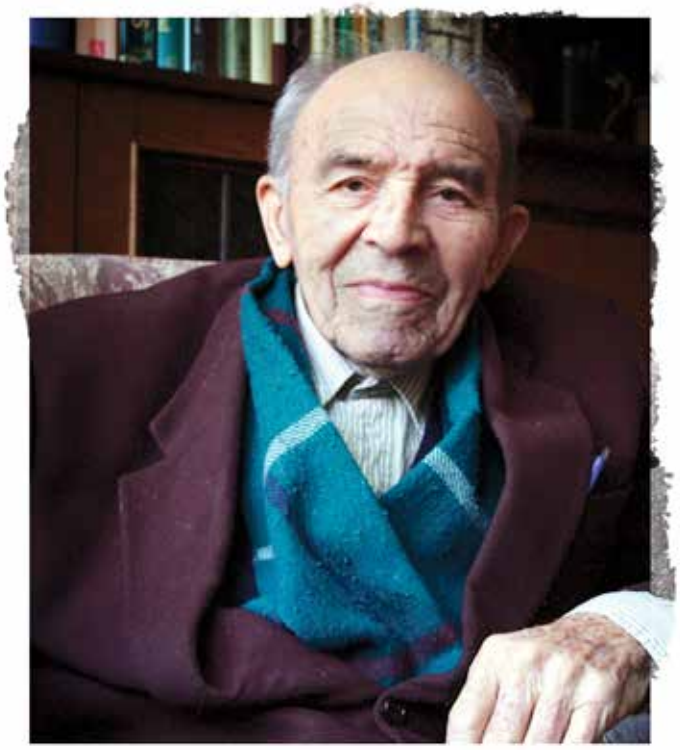
Older people

The number of older Western Australians is steadily increasing and there is expected to be almost half a million people aged 65 years and older within the next decade.[7]

While suicide rates are usually highest among people aged 85 and older they comprise only a small proportion of total deaths in this age group. There is a tendency for a greater number of medical conditions to be present in advanced age, including mental illness and dementia. A diagnosed mental illness or behavioural disorder was recorded in 23% of suicide deaths of individuals aged 75 years and over.[33]

Other significant risks for older people include social isolation, major physical or chronic illness and pain, exposure to suicide, and stressful life events such as the loss of a loved one. Research shows that 80% of people over 65 years of age experience chronic illness and this is a causal factor for 10% of suicides.[33, 36]

As the Western Australian population ages and people live longer, mental health issues will become more significant to the quality of life experienced by older people. It is essential that older people have valued roles and social connections, maintain family and social support and are able to manage chronic pain and mental health problems through self-help, peer support and access to quality, affordable services.[2, 36]



Priority populations

Children, young people and adults who have experienced mental illness, alcohol and other drug issues, trauma or exposure to suicide are at much higher risk of suicidal behaviour and death. An individual's physical, cultural and social circumstances can result in greater disadvantage and risk of suicide. *Suicide Prevention 2020* therefore outlines priority populations for suicide prevention actions across Western Australia.

People who have attempted suicide

Suicidal thinking or prior suicide attempts are common predictors of increased risk of death by suicide. SANE Australia studied people who had attempted suicide and found that many made the attempt because they felt they were 'a burden' and thought their family and friends would be 'better off' without them. A common feeling among people at the time of the attempt was of hopelessness and that their 'mental pain' would never end.[37]

Access to effective treatment and developing a trusted relationship with a health professional are critical to helping people recover from an attempted suicide. Stigma also needs to be tackled by the community and health services, as negative, dismissive or discriminatory attitudes are barriers that discourage people from seeking help.[37]

People who are bereaved by suicide

Suicide has a profound effect on others, especially where mental illness is involved. Research suggests that family, friends and carers bereaved in this way experience an added intensity of grief and are also two to five times more likely to die by suicide themselves.[37] Children who are under 18 when their parents suicide are three times as likely to take their own lives as children living with their parents.[38] Therefore, access to appropriate care, non-judgmental support and interventions for those individuals and families bereaved by suicide are key suicide prevention strategies.[31]

There is generally a poor understanding of how children and adolescents grieve and deal with the trauma associated with suicide. It must be recognised that children and adolescents deal with trauma of suicide repeatedly at each developmental phase and during significant life events.[39, 40] Further, the adults in their lives may be unable to provide necessary support while they are coping with their own loss in different ways. There is a need for early intervention, external long-term professional support and peer connections for bereaved children and adolescents in both therapeutic and social environments.[41]

Aboriginal people

The suicide rate for Aboriginal Australians is twice that of the non-Aboriginal population. Western Australia continues to have the highest rate of Aboriginal suicide in Australia: almost three times the non-Aboriginal rate.[4] Among Aboriginal young people aged 15 to 24 years, intentional self-harm rates are 5.2 times that of non-Aboriginal young people.[42]

Aboriginal people have experienced significant hardships from the impacts of colonisation, racial discrimination and the Stolen Generation. Multiple community, social and systemic factors contribute to the high rates of suicides within Aboriginal communities. Community factors encompass lack of opportunities; lack of mentors, role models and support networks; and family conflict and disintegration. Social and systemic issues include high rates of sexual assault and alcohol and other drug misuse; feuding; ongoing grief from the high number of deaths; and poor literacy levels which lead to economic exclusion and social alienation.[43]

Systemic barriers may also affect access, availability and timeliness of services to Aboriginal people. Aboriginal communities are diverse and preventing and responding to suicide risk requires culturally secure services and interventions. There should be joined-up and collaborative efforts between community leaders, traditional owners, spiritual healers, and Aboriginal and mainstream health, justice and social services.[42, 44] Ongoing support for families bereaved by suicide is critical to address layers of grief and loss.

An Aboriginal workforce skilled in suicide prevention training for families is essential. Longer term social and emotional wellbeing programs are also important to improve individual resilience, restore the family unit and create safer, stronger communities.

People from culturally and linguistically diverse backgrounds

The experience of settling in a new country as a migrant or refugee involves enormous stressors for individuals and families. These may include social

isolation; disconnection from family and friends; uncertainty over visa status; adapting to a different culture, education and employment system and language barriers. People who have experienced trauma in their country of origin, on the journey to, or arrival in Australia face additional mental health challenges.

Mental health and suicide may have different cultural meanings for people from culturally and linguistically diverse backgrounds. Stigma and taboos in some cultures may impact on an individual's willingness to acknowledge problems and seek help. Culturally appropriate mental health services and cultural competency training for workers providing support to people from CaLD backgrounds are essential to raise awareness of mental health and suicide prevention within CaLD communities.[7]

Lesbian, gay, bisexual, transgender and intersex people

Lesbian, gay, bisexual, transgender and intersex (LGBTI) individuals are at least two to three times more likely to experience depression and anxiety than the broader community, and are twice as likely to have a high level of psychological distress as their heterosexual peers.[45, 46] It is extremely difficult to gather reliable suicide statistics for these populations; consequently, LGBTI people may currently be under-represented in suicide death statistics.

LGBTI is an umbrella term used to describe a diverse range of sexual and gender minorities. While LGBTI individuals may experience specific mental health issues, the underlying factors and circumstances can vary for each person. The psychosocial stress LGBTI people face is not due to their identity as a gay or transgendered person, but because of discrimination, and social, cultural and legal barriers surrounding their sexuality and gender.[46]

Most suicide attempts by LGBTI people occur while still coming to terms with their sexuality and/or gender identity, and often prior to disclosing their identity to others or seeking counselling. Some people may experience homophobia, bullying or a lack of acceptance by family and peers. This marginalisation erodes protective factors that would usually support vulnerable people.

People living in rural and remote areas

In Western Australia the suicide rate during the period 2007-2011 was higher in rural and remote areas compared to urban and city areas.[10] Rates of suicide for males were particularly high in the Kimberley and Goldfields Health Zones at 2.0 and 1.5 times greater than the State rate respectively.[10] This increase is in part attributable to an increase in Aboriginal suicides. The alcohol and other drug related hospitalisation rate per capita for the Kimberley region was also 2.8 times higher than that reported in the metropolitan area.[47]

The combination of social isolation and lack of available services in rural and remote areas may be contributing factors to the higher suicide rates. Social stigma remains a major barrier preventing people from seeking help in many rural and remote communities.[15] Suicide prevention and crisis intervention strategies therefore need to be both adapted and led at a local level to be most effective.

People in the justice system

People in prison and on remand have a higher risk of suicide and suicide attempts. Given the higher number of Aboriginal people and homeless people in the justice system, it is estimated that each year in Western Australia around 15,000 (25%) people appearing before the metropolitan Magistrates' Courts have a mental illness. Research indicates that some people who need mental health treatment and rehabilitation are inappropriately directed into the prison system.[48]

Risk is exacerbated by the isolating effects of prison, personal history including mental illness and experiences of violence or trauma, alcohol and other drug use, regular exposure to high-risk situations and means of suicide, and barriers to treatment and rehabilitation.[48, 49] The significant over-representation of Aboriginal people in prison further highlights systemic problems.

In Western Australia reforms to the justice system and court diversion programs are being implemented to refer people with mental illness and alcohol and other drug issues into treatment and rehabilitation rather than prison. In addition, the Department of Corrective Services delivers comprehensive Gatekeeper suicide prevention training to staff and peer supporters, and there are focused efforts to reduce Aboriginal deaths in custody. However the risk of suicide among people in prison remains high.

First responders

Professions, including ambulance officers, paramedics, police officers and fire and emergency services personnel are often the first point of call in a crisis to assist people dealing with significant trauma, including those who are suicidal, those who have attempted suicide and those who have completed suicide. Referred to as first responders, this group of people are at risk of vicarious trauma and resulting burn-out, as well as the cumulative risk factors involved with exposure to all forms of trauma and suicide.[54]

To reduce the risk of suicide, first responders should have access to appropriate debriefing following a traumatic situation, as well as professional counselling on-hand as needed. Education on the risks, warning signs and symptoms of suicidal thoughts, as well as effective self-care techniques, can also be beneficial to reducing suicide amongst those working in these professions.[54]

Suicide and gender

Across Australia, men are three times more likely to die by suicide than women. In 2012, suicide accounted for 366 deaths in Western Australia, 269 men and 97 women.[4] Male suicide death rates increase with remoteness. Men living in inner regional areas experienced death rates that were 8% higher than in major cities and in very remote areas 78% higher.[50] Suicide rates for men born outside Australia are slightly lower than for Australian-born men, whereas corresponding rates for women are very similar.[19]

Thirty percent of men and half of the women in Western Australia who suicide, have previously tried to suicide before their death. Historically men attempting suicide have used more fatal means; however, there is now a trend for women to also use more severe means leading to greater adverse effects and increased fatalities.[4]

Suicides are a disproportionate cause of death for young women.[4] Factors associated with suicide among girls and women include bullying, body image dissatisfaction, sexual abuse and intimate partner violence, alcohol and other drug use, postnatal depression and other difficulties in parenthood, as well as experiences of inequality due to gender, sexuality, disability or cultural background.[51] Therefore, gender, and age group, needs to be considered in the design and implementation of suicide prevention initiatives.

Other challenges

Stigma and taboo

Stigma against seeking help for suicidal behaviour or problems of mental health or substance abuse are barriers to people receiving the help that they need. Stigma can also discourage friends and families of vulnerable people from providing them with support or even from acknowledging their situation.

In 2012 the Mental Health Commission oversaw research into the stigma associated with mental illness and effective strategies to create behavioural change. Over 1500 Western Australians were surveyed, including 300 people who had experienced mental illness. Key findings included greater experiences of stigma by people who had suicidal behaviour; more stigmatising attitudes among men aged 16 to 44 years and those who had no contact with people with mental illness; and people were less likely to disclose mental illness in their workplace due to fear of impacts on their career.[52]

Effective strategies to change stigmatising behaviour included developing the leadership of people with mental illness and sharing their personal stories; peer based education; and collaborating with general practitioners, who are often the first point of call for people with mental illness.

Raising community awareness and breaking down the taboo is essential to make progress in preventing suicide. Taboo, stigma, shame and guilt obscure suicidal behaviour. By proactively enabling people to openly discuss mental illness, suicidal behaviour and self-harm, supportive health systems and societies can help prevent suicide.[2, 53]

Media reporting, including social media

The media, including online and social media, can play a significant role in suicide prevention by raising awareness of issues, profiling people's lived experience and promoting services available to people in crisis. Media reporting on positive coping strategies in adverse circumstances, such as overcoming suicidal ideation, can have protective effects.[53]

However, irresponsible reporting and dissemination of information that sensationalises or glamourises suicide can increase the risk of 'copycat' (imitation) suicides or trigger vulnerable people.[53] Exposure

to methods of suicide has been shown to increase the risk of suicidal behaviour in vulnerable individuals.[2] Examples of inappropriate media coverage of suicide include showing photographs or information about the method used; gratuitous coverage of celebrity suicides; or normalising suicide in any way.[2]

Social media can be a source of support and help for young people. Positive use of social media is to be encouraged. However, social media can also be a negative influence on young people. The glorification of self-harm or suicidal behaviour in online discussions among young people is particularly harmful. Important in-roads are being made in this area, with Western Australia developing guidelines for managing online risks in school communities; collaborative research projects; and online suicide prevention resources and apps. With the fast pace of technological change, social media needs to be monitored and adapted as part of suicide prevention activities, and in an ongoing way.

Non-suicidal self-injury (NSSI)

NSSI is defined as deliberately injuring oneself without suicidal intent. The most common form of NSSI is self-cutting, but other forms include burning, scratching, hitting or intentionally preventing wounds from healing.

Balga Detached Youth Mural, Youth Affairs Council WA, One Life Suicide Prevention Project.

While the intention is not suicidal, NSSI needs to be better understood so that appropriate support and professional treatment is provided. People who engage in NSSI behaviour can often experience stigma, isolation, bullying, distressing emotions or trauma that may increase their risk of suicidal behaviour.

Treatment and medication

For some people with mental illness and suicidal behaviour, medication can improve symptoms and provide greater mental clarity and emotional stability to enable them to address underlying problems. However medication can also have negative side effects for people, particularly in the short term or when medication or doses have changed. Severe side effects can include suicidal ideation, and this needs to be closely monitored by the individual, along with their general practitioner or health professional and family or carers, so that adjustments to medication or other support is provided.

There is currently insufficient evidence on effective forms of treatment for patients who have recently harmed themselves. However, health services regularly contacting those who have attempted suicide for up to a year by either postcards or telephone has been found to reduce the rates of repeated suicide attempts. More formal surveillance systems have been recommended to co-exist with suicide prevention strategies.

Vicarious trauma

Staff or care-givers who are supporting people who have experienced trauma, may themselves be vulnerable to secondary trauma and burn-out that can affect their wellbeing. Symptoms of burn-out include apathy, feelings of hopelessness, rapid exhaustion, disillusionment, melancholy, forgetfulness, irritability, experiencing work as a heavy burden, and a tendency to blame oneself for perceived failings.[54]

It is vital that people working with or caring for people who are suicidal or who are bereaved by suicide, practice self-care and access appropriate debriefing. Professional training in trauma, external supervision, therapeutic awareness, structured breaks from work, and proper professional distance from clients can be extremely beneficial.[54]

EVIDENCE-BASED APPROACHES TO PREVENT SUICIDE

Resilience and protective factors

Resilience and good mental health enable people to establish healthy relationships, fulfill their potential, overcome difficulties and recover from major illness or loss. Families, friends, peers and communities have a vital role in building individual resilience and protective factors across the life stages.[8] They can also help to reduce stigma around seeking help for mental health problems or difficult life experiences; and help people stay connected, with meaningful roles and opportunities to improve their quality of life.[6]

The foundation for a long-term view to preventing suicide is to actively improve individual mental health across the life course, foster community connections and build the capacity of support networks to protect vulnerable people from harm.

Table 2: Building resilience and protective factors across life stages	
Life stages	Targeted protective factors
	**Parents, perinatal and early years** • Family physical, emotional and psychological wellbeing; • Caring and healthy relationships; • Effective parenting and coping skills; • Extended family and community support; • Positive early childhood development and healthy attachment; and • Access to child health nurses, quality childcare and local family centres.
	**School age** • Development of good self-esteem, communication and coping skills; • Supportive relationships with family, peers and the wider community; • Engagement in school, education and recreation activities; • Development of self-worth, personal safety and healthy boundaries; and • Significant adult who is a positive role model.
	**Young adults** • Ability to care for their own health and wellbeing and access support; • Capacity to create satisfying personal and social relationships; • Skills to cope with difficult emotions or problems; • Development of skills to live independently and reach personal goals; and • Successful transition from school to work or study.
	**Family & working age** • Strong identity with a sense of purpose and agency over one's life; • Activities and support for ongoing wellbeing and health or healing; • Maintaining deeper family and social relationships and responsibilities; • Opportunities to make a meaningful contribution or show leadership at home, work or in the community; and • Stable finances, employment and safe housing.
	**Older age** • Staying mentally, physically and socially active; • Opportunities to contribute and be valued by family and the community; • Managing health issues and accessing services; • Positive transition from work and family responsibilities into retirement; • Financial security, safe housing and social support; and • Drawing on own beliefs, values and wisdom to deal with change or loss.

Interventions for risk factors associated with suicide

Given the multiple factors and pathways that lead to suicidal behaviour, suicide prevention efforts should target the general population as well as key risk groups and specific contexts.

Types of interventions include:

Universal: Information and programs to reach an entire population, which aim to maximise health and minimise suicide risk by removing barriers to care, increasing access to help, and strengthening family and community protective factors.

Selective: Programs for vulnerable groups within a population based on characteristics such as age, gender, health issues or family history. While individuals may not currently express suicidal behaviours, they may have greater psychological or socioeconomic risk.

Indicated: Providing professional care to specific vulnerable individuals within the population – e.g. those displaying early signs of suicide potential or who have made a suicide attempt.

Symptom identification: Understanding signs of risk, adverse circumstances and potential tipping points for suicide, and providing support when vulnerability and risk are high.

Early care and treatment: Professional and integrated care. Monitoring and service coordination to ensure access to further information and treatment is available as needed.

Longer-term treatment and support: Preparing for a positive future by continuing care to assist with recovery and better health outcomes. Addressing background risks for suicide to remove them or reduce their impact in the future.

Ongoing care and support: Involving professionals, friends, family, workplaces and community organisations to support people's recovery and build resilience within an environment of self help. Increase broader community connection and strategies to prevent recurrences.

Postvention: Intervention after a suicide, to support individuals and communities impacted by the death. It aims to assist people who are bereaved (family, friends, professionals and peers) to recover from major stressors, grief and loss. Debriefing and support for survivors of suicide is a critical part of suicide prevention for vulnerable people.

Further information on evidence-based models, both international and Australian, is outlined in Appendix B.

The major risk factors associated with suicide can be linked to specific interventions and population health strategies. Adapted from the World Health Organization's *Preventing suicide: a global imperative*, key risk factors associated with suicide are illustrated in Figure 9, and have been grouped into areas that span across systemic, societal, community, relationship and individual risk factors. (2, 55, 56)

The complex, intersecting factors leading to suicide require coordinated responses and collaboration across multiple sectors of society. This includes community and health services and other sectors such as education, workplaces and professional associations, business, justice, law, politics, religious and faith groups, sports clubs and the media. These efforts must be comprehensive and integrated as no single approach alone can support people at risk.

Figure 8: The spectrum of interventions for mental health problems and mental disorders

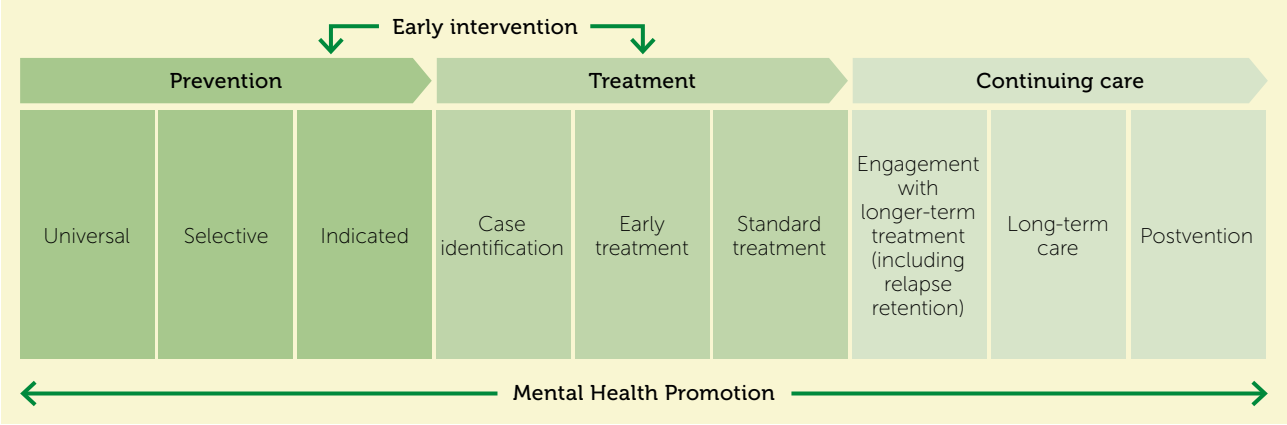


Figure 9: Key suicide risk factors aligned with relevant interventions

Contributing Factors	Key Risk Factors	Intervention	Strategy
Society	Barriers to accessing health care	Health reform, service coordination and clear referral pathways	Universal
	Stigma associated with help-seeking behavior	Public education and peer support to reduce stigma. Campaigns to promote help seeking through mental health, AOD and crisis services	
	Inappropriate media coverage	Responsible media reporting and online support	
	Access to means	Policies to restrict access to means and AOD prevention	
	Long term unemployment, financial loss, poverty or homelessness	Access to education, training, housing and social supports	
	Natural and other disasters	Resilience and capacity building programs, counselling and community outreach	
	Conflict or neighbourhood crime	Programs, empowerment and support for marginalised groups	Selective
	Stress from cultural dislocation or discrimination	Gatekeeper Training for GPs, teachers and professionals	
Relationships	Relationship conflict, separation or grief	Counselling, healthy relationship programs, crisis phone helplines and online support	
	Isolation or lack of social support	Community connection and follow up support	Indicated
Individual	Previous suicide attempt or suicidal behaviour	Professional assessment and ongoing management of suicidal behaviours	
	Experience of mental illness	Clinical assessment and management of mental illness and AOD use	
	Harmful use of alcohol or other drugs	Peer support for individuals, families and carers	
	Chronic pain, illness or disability	Integrated health and mental health programs and self help	Universal
	Hopelessness or low self esteem	Programs to build self esteem, communication and problem-solving skills	
	Risk-taking behaviour	AOD prevention, sexual health programs, healthy role models	
	Exposure to suicide	Counselling and peer support after loss by suicide	Early care and treatment
	Experience of trauma	Trauma informed care and workforce training, cultural healing	
	Disengagement from education, employment and health services	Integrated, multi-sector programs and coordinated follow up	Longer-term treatment and support
		Interagency systems for early identification and interventions to address cumulative trauma	
	Involvement in the justice system	Gatekeeper Training in closed organisations such as prisons	
	Experience of family violence, sexual or physical abuse, or neglect	Cross-government approaches to prevent abuse, and provide integrated care and follow up	Ongoing care and support
	Intergenerational transfer of risk	Strengthen families and vulnerable groups across life stages	

WESTERN AUSTRALIAN MODEL

2009-2013 Suicide Prevention Model

The Western Australian Suicide Prevention Strategy 2009-13 closely reflected the national LIFE framework, with six main action areas spanning a wide range of actions requiring community, government, private sector and community managed sector participation.

The 2009-13 Strategy had a strong focus on capacity building and awareness raising through local Community Action Plans for suicide prevention. It aimed to provide communities with the skills, understanding and resources to increase individual resilience; reduce stigma around mental illness and suicide; identify and respond to suicide risks; encourage access to appropriate services and supports; and establish greater collaboration across services.

Throughout 2014/15 evidence-based training programs have continued to be provided to local communities, specifically Gatekeeper, Mental Health First Aid and Applied Suicide Intervention Skills Training. Between 2014 and 2015, leadership and local action to prevent suicide has been maintained through small community grants with over 60 diverse projects delivered so far.

In 2012, the School Response to Suicide and Self-harm Program was established in response to increased suicide deaths, suicide attempts and self-harm among teenagers in Western Australia. The program provides extra specialist clinicians through the Department of Health Child and Adolescent Mental Health Service, Department of Education School Psychology Services, and non-government youth mental health service, Youth Focus. The integrated program is increasing access to counselling and suicide prevention education for young people at risk; and supporting school communities and parents to appropriately prevent and respond to suicidal behaviour, including developing guidelines for managing related social media issues.

The 2009-13 Strategy was supplemented by complementary initiatives including the Mental Health Commission investing around $1.7 million per annum in suicide prevention, early intervention and crisis counselling services such as Lifeline and Youth Focus.

The Strategy Research, Development and Evaluation Report by Centrecare and Edith Cowan University found that there was considerable local engagement with 45 Community Action Plans. These plans covered 255 locations and at-risk groups such as Aboriginal communities, young people, men, regional communities, culturally and linguistically diverse communities, homeless people, and diverse sexuality and gender groups.

In particular, mental health and suicide prevention training delivered through Community Action Plans demonstrated significant benefits for individuals and communities. This training increased people's capacity to recognise the signs and symptoms of mental illness, be more supportive of their peers and colleagues, and refer people who were at-risk or experiencing a crisis to appropriate professional help. The corporate, business, government and community sectors also strongly supported the 2009-13 Strategy, with over 260 organisations committed to delivering mental health and suicide prevention training, and awareness activities for their employees.

The Auditor General's Report highlighted numerous benefits reported from Community Action Plans including:

1. Stigma of mental health issues and suicide were reduced;
2. People were trained to deal with mental health problems;

3. Understanding of suicide and knowledge of warning signs and ways to respond had improved;
4. People in need of help were more likely to seek help;
5. Back to country camps were well received by young Aboriginal people;
6. Community engagement and strengthening the community spirit was achieved through local events; and
7. Agency pledge partners had positive feedback on Working Minds Training.

The Auditor General also found that Kimberley Community Action Plans reported that:

- A dedicated suicide prevention coordinator was needed and the Community Coordinator was a first point of contact;
- Community events such as football matches, coffee morning and music workshops were happy occasions that brought people together, rather than just funerals;
- Training programs such as ASIST, Gatekeeper and Mental Health First Aid were useful and were used in successful suicide interventions; and
- Participating in the Aboriginal Leadership and Empowerment program had been life changing for some people and enabled them to develop important life skills.

Areas for improvement that were identified in the Strategy Research, Development and Evaluation Report included:

- Adequate planning to establish realistic outcomes, ensure the needs of at-risk groups are met and specific strategies are developed for Aboriginal communities;
- Develop a management plan to document policies, procedures and responsibilities for implementation;
- Assessing community readiness for suicide prevention activities and better defining sustainability as behaviour change, community engagement or active involvement;
- The need for longer term resourcing of community activities and implementation over five years and adding value to existing effective programs;
- A dedicated, qualified suicide prevention officer embedded in a sustainable model, such as an existing health or mental health service;
- Consider embedding Aboriginal suicide prevention activities into established programs such as art, language and school workshops;
- Encouraging businesses to support suicide prevention in their community through sponsorships or partnerships; and
- Utilising developmental evaluation approaches and establishing and evaluation group overseen by the Mental Health Commission.

The Western Australian Auditor General's recommendations for improvement were:

1. Develop quantifiable and objective measures to complement qualitative reporting and allow more consistent assessment of suicide prevention activities to inform strategy development;
2. Develop an overarching implementation plan;
3. Review the governance structure and clearly define roles and responsibilities of all parties; and
4. Identify, collaborate and coordinate with existing suicide prevention efforts to increase efficiencies and the likelihood that benefits will be sustained.

Further, the Western Australian Ombudsman's Investigation into suicides of 13-17 year olds in Western Australia, found that universal suicide prevention activities were beneficial. However, given the cumulative trauma experienced by the majority of teenagers who suicide, the next suicide prevention strategy should prioritise increased resources and efforts on early intervention, treatment and continuing care for vulnerable young people.

These findings have been addressed in *Suicide Prevention 2020*.

The model for *Suicide Prevention 2020*

Suicide Prevention 2020 will comprise six key action areas:

1. Greater public awareness and united action.
2. Local support and community prevention across the lifespan.
3. Coordinated and targeted services for high-risk groups.
4. Shared responsibility across government, private and non-government sectors to building mentally healthy workplaces.
5. Increased suicide prevention training.
6. Timely data and evidence to improve responses and services.

These action areas will be underpinned by collaborative and coordinated initiatives across multiple agencies and sectors and will be strongly guided by culturally and age-appropriate community engagement.

The action areas are all supported by specific strategies highlighted in evidence-based approaches to suicide prevention including: The national Living is for Everyone (LIFE) Framework; *National Aboriginal and Torres Strait Islander Suicide Prevention Strategy 2013*; World Health Organization directions outlined in *Public Health Action for the Prevention of Suicide: A Framework* (2012); *Preventing Suicide: A global imperative* (2014); and *Social Determinants of Mental Health* (2014). Key elements of models supported by the World Health Organization, European Optimizing Suicide Prevention Intervention and the Australian National Coalition for Suicide Prevention are outlined in Appendix B.

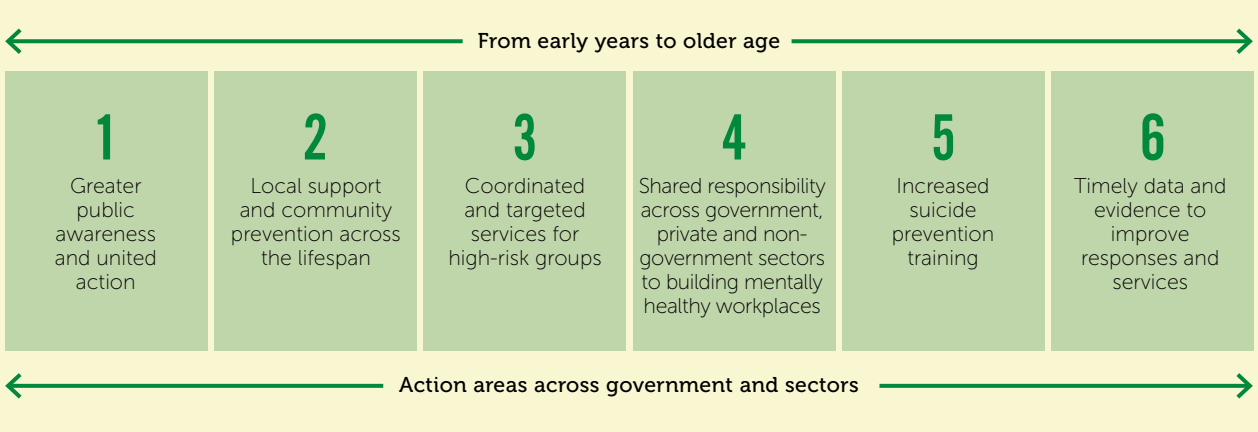
This information has been supplemented by the findings of the 2012 *Review of the admission or referral to and the discharge and transfer practices of public mental health facilities/services in Western Australia* by Professor Bryant Stokes; Strategy *Research, Development and Evaluation of the 2009-2013 Suicide Prevention Strategy*; and the reports conducted by the Western Australian Ombudsman and Auditor General in 2014.

It is intended that relevant action areas will be adapted by communities, workplaces, corporate organisations, services and government agencies to deliver tailored responses for their local populations, members, staff, clients and networks. A range of activities will be delivered through collaborative partnerships, local community prevention programs and integrated services.

Early priorities will be implemented through the Mental Health Commission in collaboration with the Ministerial Council for Suicide Prevention, strategic partners, services and relevant government agencies. A *Suicide Prevention 2020* Implementation Plan for 2015-2020 will detail activities, resources and lead agencies required. The Implementation Plan will define actions, allocate responsibility, and identify outputs and outcomes. Progressive independent evaluation will be implemented to enable effective monitoring and reporting to ensure ongoing improvement.

Actions that are significantly related to mental health, alcohol and other drug promotion, prevention and service delivery will also be concurrently addressed through the *Mental Health, Alcohol and Other Drug Services Plan 2015-2025*.

Figure 10: Suicide prevention throughout the life course



WHAT WE WILL DO - KEY ACTION AREAS

Suicide Prevention 2020 identifies six key action areas for united action across communities, sectors and government agencies. These action areas and early priorities are intended to build on previous suicide prevention activities in Western Australia, and are informed by recent evaluations, current data, and international and Australian evidence-based approaches.

1. Greater public awareness and united action

Educating the public about suicide risk factors and what to do when someone is suicidal is an integral part of effective suicide prevention. Mobilising the community and creating an appetite for change is achieved through effective communication and community engagement.

This action area will be achieved through:

1.1 Implementing a comprehensive communications strategy, including multimedia resources and media partnerships.

1.2 Delivering a comprehensive public education campaign and resources tailored to specific age groups and populations.

1.3 Promoting the use of mental health, counselling, alcohol and other drugs services, and reduce stigma and discrimination against people using these services.

1.4 Facilitating events to create community dialogue and inspire action.

1.5 Profiling the stories of bereaved families to create understanding and empathy, and reduce stigma around seeking help.

1.6 Providing opportunities for people with lived experience to share their stories to reduce stigma around accessing services.

Early priorities

1.1.1 The Mental Health Commission will develop a comprehensive communications strategy, with the One Life website (www.onelifewa.com.au) acting as a hub for suicide prevention information, research and services. Partnerships with Mindframe will promote responsible reporting of suicide in the media.

1.2.1 The Mental Health Commission will continue strategic partnerships to promote universal suicide prevention awareness.

1.3.1 and 1.4.1 The State Government will build on the strong community engagement achieved through the previous State Suicide Prevention Strategy by continuing to provide small grants for local community activities, including public forums and events.

1.5.1 and 1.6.1 To tackle stigma and misunderstanding, the experiences of individuals and families affected by suicide will be profiled on the One Life website, in multimedia resources and through media partnerships.

Examples of successful projects and partnerships to increase community awareness

Research highlights that participation in sport and recreation builds considerable social capital, including "networks of mutual support, reciprocity and trust that may benefit health, education and employment outcomes for individuals while also fostering community strength and resilience." [57] According to the ABS 2006 General Social Survey, among people aged 18 years and over, sports participants had more frequent contact with family and friends, a greater number of friends to confide in and greater ability to obtain support in times of crisis.[57] *Suicide Prevention 2020* will, therefore, continue to utilise the Western Australian Football Commission (WAFC) and Netball WA's extensive networks to promote One Life suicide prevention messages and services to reach a combined audience of around 68,000 Western Australians.

Since 2011 the One Life and WAFC partnership has targeted over 50,000 Western Australian football players across the State. WAFC coaches, players, volunteers and executive undertake suicide prevention training and engage in mental health campaigns. To increase the resilience and well-being of young males, a typically at-risk group, are 2,800 coaches trained to recognise and respond to signs of suicidal behaviour and promote healthy choices.

In 2014, a new partnership between One Life WA and Netball WA enabled 400 coaches to be trained in mental health and suicide prevention through Youth Focus and Relationships Australia. Their increased understanding and skills will ensure coaches and players are confident in supporting teammates, family or friends in need of help. Netball WA's One Life Ambassadors will reach 18,000 netball players.

A marketing research report, Community attitudes toward mental illness was undertaken in 2012.[52] The Mental Health Commission contracted TNS Social Research (TNS) to survey over 1500 West Australians, including 590 people who self identified as consumers. The results highlight current community attitudes towards mental illness, and support for strategies to reduce stigma and create positive behaviour change.

Questions were asked about mental illness generally and specific conditions to identify priority target groups. Consumers were asked additional questions about their experiences of stigma, accessing services and help-seeking behaviours. Communication approaches and messages were tested with consumers and community members using online bulletin boards.

A strong theme in creating behaviour change was the importance of humanising issues, such as showing the faces of people with a mental illness, their personal stories and journeys, and recovery. Personal stories, panel discussions and documentaries were easier to relate to.

Messages that resonated with audiences highlighted the positive contributions of people with a mental illness; making a difference by challenging discrimination; the importance of connecting with peers to reduce isolation; and taking positive action to improve individual mental wellbeing.

The Mental Health Commission is utilising the research to enhance existing stigma reduction activities including the Music Feedback youth anti-stigma campaign (www.musicfeedback.com.au) and peer-based programs.

The FIVE Project is a two-year partnership between Disability in the Arts, Disadvantage in the Arts and Rio Tinto to engage communities in discussions around mental health. It focuses on Fly-In, Fly-Out and residential workers, and their families, as well as young people, Aboriginal people and farming communities. FIVE works through a series of community arts and cultural development projects in Paraburdoo, Busselton, Geraldton, Derby and Esperance that combat social isolation and stigma for groups at-risk of mental illness. FIVE projects stimulate community dialogue about mental illness, community wellbeing and provides opportunities to improve social connections and communication skills.

The initiative supports the Mental Health Commission's *Mental Health 2020* strategy, one component of which is to build peer-to-peer connection as a means of facilitating dialogue around mental health. FIVE addresses findings from recent research noting lack of communication and social isolation as contributing factors to poor mental health – particularly among the State's regional communities. It is the first collaborative project to emerge from a unique memorandum of understanding between Rio Tinto and the Mental Health Commission that outlines a commitment to projects that support mental illness prevention and anti-stigma. FIVE will be evaluated in partnership with researchers from Murdoch University. For more information see: www.five.org.au.

The Regional Men's Health Initiative (RMH) is a project that aims to educate men in rural Western Australia on mental health and suicide through community education. Developed in 2002 in response to the increased suicide risk in regional men, RMH aims to empower men, their families and communities to take responsibility for their wellbeing and mental health. RMH presents at over 150 events a year to speak about support mechanisms for men and those affected by traumatic events, as well as to establish sustainable support mechanisms that reduce social isolation and encourage help-seeking behaviour. RMH also offers the Fast Track Pit Stop Program which teaches men about health awareness and listening. More information on RMH can be found on their website at www.regionalmenshealth.com.au.

This FIFO Life is an online resource for FIFO workers, their families and friends in Western Australia, funded by the Mental Health Commission. The website, focusing on the strength and resilience of FIFO workers, features resources and tips for staying mentally healthy. The website uses a mixture of pictures, videos, blogs, articles and links on the many issues relating to mental health and FIFO workers. The website was co-produced through consultation and profiles the voices of people with lived experienced of mental illness. This FIFO Life promotes access to services and recognises the unique needs of FIFO workers as a priority group for mental health in Western Australia. This FIFO Life is available at www.thisfifolife.com.

2. Local support and community prevention across the lifespan

Preventing suicide requires a strong local approach with skilled suicide prevention coordinators integrated with mental health and alcohol and other drug services, and with strong connections to interagency government, health and community service committees.

This action area will be achieved through:

2.1 Promoting and supporting evidence based and culturally informed mental health literacy programs.

2.2 Strengthening community based suicide prevention activities, local capacity building and leadership.

2.3 Collaborating with local stakeholders to strengthen suicide prevention protocols, establish ways to reduce access to means of suicide and map pathways to care to appropriate services and support. This may include increased telepsychiatry and videoconferencing mental health services to support regional communities.

2.4 Partnering with primary care providers to address mental health needs and risk factors.

2.5 Ensuring communities have the capacity to respond to crises and can access emergency services, crisis support and helplines.

2.6 Improving postvention responses and care for those affected by suicide and suicide attempts.

Early priorities

2.1.1 The Mental Health Commission will seek resources to expand a number of existing services across the State to better support people at high risk. This will include increasing mental health training, early intervention and suicide prevention programs for young people, men and women, families experiencing trauma, Aboriginal communities, regional communities and lesbian, gay, bisexual, transgender and intersex groups.

2.1.2 Training in Gatekeeper suicide prevention and trauma informed care will be increased for frontline workers, health professionals and para-professionals.

2.2.1 and 2.3.1 The Mental Health Commission will phase in qualified suicide prevention coordinators within mental health and/or drug and alcohol services across regions in need. The suicide prevention coordinators will be integrated into mental health and alcohol and other drug services, with stronger connections to interagency government, health and community service committees to consolidate collaboration across sectors. This is consistent with recommendations contained in the evaluation of the 2009-13 Strategy and will strengthen sustainability of localised, strategic community coordination by improving local coordination. The Centrecare and Edith Cowan University evaluation of Community Action Plans suggested that community coordinators should be overseen by the Mental Health Commission and co-located with relevant mental health services.

This will be a phased in approach to ensure community readiness, service responsiveness and ongoing improvement. The qualified suicide prevention coordinators will initially be located in north and east metropolitan Perth, and the Kimberley, South West and Wheatbelt regions. The program design will adopt the best elements of the previous Community Action Plans and existing alcohol and other drugs prevention model in Western Australia.

2.5.1 National crisis lines and online resources funded by the Commonwealth will be promoted across Western Australia including Suicide Call Back Service, Reachout, headspace, beyondblue and QLife. Crisis support lines and programs such as Lifeline, beyondblue and The Samaritans will continue to be funded through the Mental Health Commission and enhanced through stronger partnerships.

2.4.1 and 2.6.1 Increased services for people who have attempted suicide will be established. This will include support to general practitioners and their patients who present with suicidal or self harm ideation and patients discharged from hospital Emergency Departments that have attempted suicide, engaged in self harm or present with ideation around self-harm or suicide. An intensive case management system will provide comprehensive assessment, face to face and telephone counselling, through care and a co-case management model with the patient's general practitioner, as well as linking the client with health and social services in response to identified needs.

Examples of community support services available

Crisis counselling and national mental health programs are key resources for local communities to promote and access. They are free to use and can provide several phone and online sessions or referrals for face-to-face counselling and programs. The following services are not for profit and funded by State and/or Commonwealth Governments.

Lifeline services include a 24/7 telephone crisis line, online crisis support, service directories, mental health resource centres and information. Visit www.lifeline.org.au or call 13 11 14 for support.

beyondblue aims to raise awareness of depression and anxiety, and increase the mental wellbeing of all Australians at all stages of life by increasing access to support. *beyondblue* delivers counselling support and has information for individuals, families and the Aboriginal community on overcoming suicidal thoughts or attempts. For more information visit www.beyondblue.org.au or phone 1300 22 4636 for support.

The Suicide Callback Service (SCS) provides 24/7 phone and online counselling to those experiencing a mental health crisis. It is available to people 15 years and over who are suicidal, are caring for someone suicidal, have been bereaved by suicide, or are health professionals supporting people affected by suicide. SCS offers up to six further counselling sessions with the same counsellor, to address the ongoing needs and time-based risk factors for vulnerable individuals. Phone 1300 659 467 or visit www.suicidecallbackservice.org.au.

3. Coordinated and targeted services for high-risk groups

Suicide Prevention 2020 takes an evidence based approach to reducing suicide risk across the lifespan, which reflects current research by the World Health Organization. The most common and significant factor in suicide is mental illness, which is present in up to 90% of people who die by suicide. The following people are recognised to be at greater risk of suicide than the general population:

- People dealing with trauma in the workplace, including first responders and former defence force personnel;
- People bereaved by suicide, particularly children;
- Aboriginal people;
- People from culturally and linguistically diverse backgrounds;
- Lesbian, gay, bisexual, transgender, and intersex people;
- People living in rural and remote areas;
- People in the justice system;
- Those who have attempted suicide; and
- People who use alcohol or other drugs.

Ensuring that services are coordinated and targeted to high-risk groups and across the lifespan is essential to preventing loss of life to suicide.

This action area will be achieved through:

3.1 Facilitating effective interagency coordination to address social determinants for suicide prevention across the lifespan.

3.2 Co-producing new programs with the at-risk groups themselves, including people with lived experience, family members and carers.

3.3 Delivering responsive, high quality treatment and support for those with mental illness, aligned with the *Mental Health and Alcohol and Other Drug Services Plan 2015-2025*.

3.4 Improving policies, protocols, discharge planning and continuing care for people who have self-harmed and/or attempted suicide.

3.5 Strengthening early intervention services and family counselling to prevent and address cumulative trauma in children and young people.

3.6 Supporting interagency postvention responses for individuals, families and communities who have lost someone to suicide.

Early priorities

3.1.1 An Interagency Implementation Plan will be established to map and enhance relevant government and non-government resources, programs and responsibilities in suicide prevention across the State.

3.2.1 A *Suicide Prevention 2020* Aboriginal Implementation Plan will be developed with dedicated resources.

3.2.2 The Mental Health Commission will develop a youth engagement strategy to ensure suicide prevention activities are relevant to young people across Western Australia.

3.1.2 The State Government will strengthen the Response to Suicide and Self-Harm in Schools Program ('School response'). This encompasses coordinated and free counselling, education and treatment for young people at risk to help them overcome issues associated with depression, suicide, self-harm and grief from suicide by family or friends. It is delivered by specialist staff through the Department of Education School Psychology Service, Department of Health Child and Adolescent Mental Health Service, and non-government service Youth Focus. The School response will be expanded, as resources become available, to the Mid-West, Wheatbelt and the Great Southern where there has been significant need.
Increased mental health and suicide prevention education programs in Curriculum and Re-engagement schools will also be delivered. This will ensure vulnerable young people who may have previously missed out on health education are better equipped around improving their mental wellbeing, supporting their peers and accessing appropriate services when needed.

3.2.3 and 3.3.1 *The Mental Health and Alcohol and Other Drugs Services Plan 2015-2025* will be overseen by an Implementation Working Group.

3.5.1 The Mental Health Commission will increase resources to early intervention programs and family counselling to support vulnerable children who are at risk of or experiencing cumulative trauma.

3.5.2 The Mental Health Commission will work with the Department of Child Protection and Family Support, Department of Education, Department of Health and other relevant agencies to deliver prevention and early intervention initiatives for vulnerable children at risk of abuse, neglect and cumulative trauma in line with recommendations by the Western Australian Ombudsman.

3.6.1 The Mental Health Commission will continue to liaise with the Commonwealth to strengthen bereavement support for people individuals, families and communities.

3.6.2 Specific programs for postvention support for children bereaved by suicide will be established by the Mental Health Commission.

Examples of current initiatives to improve outcomes for vulnerable groups

The Response to Self-Harm and Suicides in Schools, is a coordinated interagency model funded by the State Government. It comprises:

- specialist clinicians at Child and Adolescent Mental Health Service to provide assessment, treatment and counselling;
- specialist psychologists at the Department of Education to improve suicide prevention, crisis responses and postvention support across the three school systems; and
- Youth Focus (non-government youth mental health service) school liaison coordinator, three specialist psychologists and a mental health trainer. This will assist priority school communities and provide intensive counselling to hundreds of at-risk young people.

The Living Proud Suicide Prevention Community Action Plan addressed the significantly higher rates of suicide and mental illness that affect the lesbian, gay, bisexual, transgender and intersex (LGBTI) community. The project sought community input with the LGBTI community themselves to develop its response, aiming to reduce stigma and discrimination against LGBTI people as well as increase awareness of the issues that LGBTI people face. Members of the community were trained in courses designed to increase resilience, competency in responding to suicide, and education in mental illness, including Training4Trainers and Applied Suicide Intervention Skills Training. Resources that featured information on support specifically for LGBTI people were created and distributed.

Living Proud – Opening Closets training program was delivered to frontline mental health workers in Perth. Funded by the Mental Health Commission, the free training aims to increase knowledge of LGBTI needs, issues and understanding. The program also develops the capacity of individuals and workplaces to respond to LGBTI individuals. More information is available at www.livingproud.org.au.

The LGBTI action plan was further supported through research from the national Mindout project by the LGBTI Health Alliance and the QLife service (www.qlife.org.au) which provides early intervention, peer-supported telephone and web based services for LGBTI people.

The Youth Affairs Council of Western Australia Suicide Prevention Community Action Plan was created to support suicide prevention efforts for homeless young people in Western Australia, as they face significantly higher suicide risks than the general population. The action plan involved direct engagement with the homeless community through peer support workers. Guidelines and recommendations were developed for Youth Service Providers working with young homeless people at risk of suicide were developed and distributed to inform best practice and address gaps in service. It utilised existing networks and workshops to advertise referral pathways for homeless young people based on their complex needs.

When Someone Takes Their Own Life... What Next? is a resource developed by the Mental Health Commission designed to offer practical advice and support to a person who has lost someone to suicide. The resource provides information on coping with grief and loss, counselling and support services; and practical matters such as the role of the Coroner's office, finance, how to talk to children and funeral arrangements. The resource was created with extensive consultation from people who have lost someone to suicide in the past, and includes personal tips and quotes from those consulted. It is available at www.onelifewa.com.au.

4. Shared responsibility across government, private and non-government sectors to build mentally healthy workplaces

Recognising that most deaths by suicide are among people of working age, *Suicide Prevention 2020* will build on the previous agency coordination program with a strengthened workplace suicide prevention program that shares guidelines, protocols, training programs, planning tools and best practice.

This action area will be achieved through:

4.1 Assisting organisations to fulfil their responsibilities and legal obligations for the mental wellbeing and safety of their employees.

4.2 Developing implementation, monitoring and accreditation systems for workplace mental health and suicide prevention initiatives.

4.3 Setting minimum requirements for mentally healthy workplaces, including training to identify and support people at risk.

4.4 Acknowledging and disseminating best practice approaches to creating a mentally healthy workplace.

4.5 Encouraging large government and corporate organisations to have mental health and suicide prevention as a key outcome measure with adequate resources and monitoring.

Early priorities

4.1.1 The Mental Health Commission will establish a strategic Workplace Suicide Prevention Program for agencies across Western Australia to utilise; and a formal network to provide ongoing policy and planning support to staff leading these activities.

4.2.1 and 4.3.1 The Mental Health Commission will promote minimum requirements and accreditation systems for mentally healthy workplaces and disseminate best practice examples. This will be done in collaboration with relevant community, health, education, government and corporate agencies. Industries and workplaces with populations at higher risk (e.g. young people, men, regional and Aboriginal staff), large employers and peak bodies will be prioritised to ensure appropriate reach across Western Australia.

4.4.1 and 4.5.1 The Workplace Suicide Prevention Program will build on previous One Life agency initiatives and link to current workplace mental health and suicide prevention training and tools developed by organisations such as beyondblue, SANE and Black Dog Institute. The Mental Health Commission will provide guidelines and resources which assist workplaces to plan, implement and monitor suicide prevention activities.

4.4.2 and 4.5.2 The State Government will continue to support initiatives such as the Regional Men's Health Initiative and Mates in Construction to reach men in regional areas and working in Fly-In, Fly-Out communities. Collaboration with corporations, local government and services will ensure employees and their families can access counselling, peer support, education and crisis support.

Examples of effective workplace programs

Suicide Prevention Action Plans for the workforce were established to prevent suicide under the State Suicide Prevention Strategy by numerous organisations and professional bodies.

MATES in Construction (MATES) has an industry approach to suicide prevention in workplaces in the construction industry, which face high rates of suicidal thoughts. MATES aim to enhance support, open discussion of suicide, and make better connections between workers and external professionals. MATES delivers three types of training programs on-site, including Connector Training to train workers to be competent in responding to crises and connecting others with help, General Awareness Training, and ASIST Training which trains workers to respond to someone contemplating suicide and increase their safety. MATES has on-site access to peer connectors to help workers access relevant services. Nearly 6,000 construction workers in Western Australia have completed MATES training, and over 300 have received individual support from a MATES case manager. MATES draws from contemporary evidence on suicide prevention and practice-based experience. It has a clear theory of change which draws on community development practice.

The Department of Fisheries formed a Suicide Prevention and Awareness Working Group, comprised of volunteers representing different sectors of the department, in May 2011. The Working Group conducted a mental health and wellbeing survey with numerous follow-ups and aimed to build individual resilience, capacity for self-help, and take a coordinated approach to suicide prevention in the workplace. The Working Group developed an agency plan to improve mental health, communicated resources to staff through email and intranet, and provided Gatekeeper and Mental Health First Aid Training to its staff. Results of follow-up surveys showed a great improvement in staff knowledge of where to access services and self-reported wellbeing.

The Australian Veterinary Association (AVA) has adopted a strong commitment to suicide prevention in the workplace through their action plan. Veterinarians face a suicide rate four times higher than that of the general population. Veterinarians experience unique work stressors which are compounded by 24/7 access to lethal drugs. The AVA established mentoring for new veterinary graduates to prevent isolation and to link them to support networks within their profession. With a model geared towards fostering positive psychology and encouraging resilience, the AVA has created projects to connect veterinarians to each other between metro and rural areas such as the Australian Veterinary Orchestra.

The State Government employs around one fifth of Western Australia's workforce. **The Public Sector Commission and Western Australian Mental Health Commission** produced the *Supporting Good Mental Health in the Workplace* resource for the public sector to highlight the importance of good mental health in the workplace. It provides information about:

- the legal and ethical responsibilities of employers;
- activities and strategies for creating a trusting and inclusive work environment;
- steps to reduce the stigma of mental health problems; support and retain staff; and improve the working environment; and
- resources and support services for HR staff and line managers.

Visit the Public Sector Commission website to find out more.

There are a range of effective mental health training programs and tools available.

Developed by the **Mentally Healthy Workplace Alliance and beyondblue**, Heads Up calls on business leaders to make a commitment and start taking action in their workplaces. One of the key features of the website is a tailored action plan tool for organisations to identify specific ways they can make their workplace more mentally healthy. Visit: www.headsup.org.au.

Mindful Employer is SANE Australia's mental health in the workplace training program, available to any business nationwide. It can be run as a series of face-to-face workshops, a remote eLearning program or a combination of the two. It can also be adapted to fit the industry and specific workplace roles of participants. Visit www.mindfulemployer.org.

Mental Health in the workplace and wellbeing program The Black Dog Institute provides flexible, customisable training and online resources to suit staff at all organisational levels. Delivered by experienced mental health clinicians, programs focus on measurable data and results. Visit www.blackdoginstitute.org.au.

5. Increased suicide prevention training

Suicide prevention training aims to upskill the community in order to increase personal resilience and competence in supporting and identifying someone with suicidal ideation or suicidal behavior. Education in suicide prevention can cover understanding common mental illnesses and reducing stigma; how to discuss suicide with someone who may be at risk; identifying warning signs and referring people to appropriate professional help.

This action area will be achieved through:

5.1 Promoting training and self-help activities for high-risk groups and peer support.

5.2 Supporting mental health and suicide prevention training in schools, vocational and tertiary education sectors and community groups.

5.3 Coordinating Gatekeeper and other programs for professionals and para-professionals including General Practitioners, health workers and frontline service providers.

5.4 Embedding trauma informed practice in the mental health workforce.

5.5 Backing up training with adequate supervision and de-briefing mechanisms.

Early priorities

5.1.1 and 5.2.1 The State Government will continue to provide training grants and coordination to enable local communities to access evidence-based mental health and suicide prevention training.

5.3.1 Evidence-based training programs are key to skilling the community in how to deal with suicide risk and behavior effectively. A well-trained and competent emergency services workforce can greatly contribute to suicide prevention efforts. Gatekeeper training will be expanded across the State with frontline workers in education, health, police, welfare and corrective services receiving training every three years.

5.4.1 Trauma informed care and specialist suicide prevention training for at-risk groups such as people who are bereaved by suicide, young people, Aboriginal communities, first responders and LGBTI groups will be supported.

5.5.1 The Mental Health Commission will promote supervision and de-briefing guidelines and best practice on the One Life WA website.

Examples of evidence based training available in Western Australia

The Ministerial Council for Suicide Prevention has developed a Directory of Mental Health and Suicide Prevention Programs available on the One Life WA website (www.onelifewa.com.au) which have been assessed as demonstrating evidence informed practice and are appropriate for various settings and target groups such as young people, Aboriginal communities and service providers.

The Council has also revised the **Gatekeeper Suicide Prevention Training** which is tailored for Western Australian professionals and para-professionals whose roles bring them into regular contact with young people and adults at risk of suicide. The two day course teaches participants to identify and respond to people at risk of suicide and provides a framework for risk assessment and intervention. Gatekeeper training draws on national and international research and a large evidence base, using the Western Australia Coroner's database and the Australian Bureau of Statistics data for trends and suicide patterns. It is widely delivered across schools, health and corrective services.

Engaging frontline workers In 2015 the Western Australian Ministerial Council for Suicide Prevention hosted a forum for emergency services personnel, mental health emergency workers and school psychologists to enhance their skills to effectively address suicide and critical incidents. Former US Police Sergeant Kevin Briggs delivered the keynote presentation and spoke of his experience patrolling San Francisco's Golden Gate Bridge and successfully intervening in hundreds of suicide attempts. Sergeant Briggs provided insights into effective communication approaches for suicide prevention and first responders. He also spoke of his own experience with depression and encouraged professionals to look after their mental health through self-care, support systems and professional care.

This followed a previous presentation in 2014 where Mr Briggs spoke to front line responders at a forum via a Skype presentation.

Trauma Informed Care can significantly help people who have experienced severe trauma to recover from mental illness and related problems; and also prevent further harm through inappropriate organisational practices or culture. In 2014, the Mental Health Commission coordinated training by Adults Surviving Child Abuse for 335 staff of public mental health services, along with staff from alcohol and other drug services. Training was also provided for clinicians and managers from community managed organisations in the mental health sector. The training covered system-wide application of trauma-informed care and practice. Research shows that because large numbers of people who experience trauma-related problems access broad services beyond mental health, it is critical that the full range of human service delivery is based on trauma-informed principles.

6. Timely data and evidence to improve responses and services

The complexity and changing nature of suicidal behaviour necessitates that up-to-date research and evaluation measures inform and direct prevention strategies and training. Emerging trends and suicide 'hotspots' require information that is current and accurate so that services can respond appropriately.

This action area will be achieved through:

6.1 Collating, analysing and disseminating the latest research and evaluation reports on risk and protective factors and evidence-based programs.

6.2 Monitoring and evaluating initiatives for ongoing improvement.

6.3 Establishing a taskforce to monitor, improve and utilise suicide related data to inform planning, intervention and postvention responses.

Early priorities

6.1.1 The One Life WA website will continue to promote the latest research on suicide prevention and related issues.

6.2.1 Programs funded by the Mental Health Commission will be progressively evaluated to build the evidence base of what works.

6.3.1 The Mental Health Commission will work with the Coroner's Office, Western Australian Police and Telethon Kids Institute to establish a Suicide Prevention Data Taskforce to improve data collection, coordination, monitoring and reporting across the State. The taskforce will include relevant government agencies, services and researchers to progress the following:

- Ensure data collection aligns with national standards and is linked across coronial, police, health, child protection, education, alcohol and other drug and ambulance systems;
- Collate ambulance and hospitalisation data, and community surveys on suicide attempts and treatment to improve interventions and support recovery;
- Support data collection on high-risk groups, including Aboriginal communities, and any emerging suicide clusters to ensure appropriate responses;
- Monitor the methods for suicide and suicide attempts to ensure means restriction efforts are responsive to changing patterns; and
- Improve utilisation of data to improve suicide prevention, intervention and postvention activities.

Current data sources

Australian Bureau of Statistics (ABS) is the statutory agency responsible for analysis and reporting of mortality data in Australia, including suicide. Data on suicide deaths is sourced from the State and Territory Registrars of Births, Deaths and Marriages and supplemented by information from the National Coroners Information System. Published data on suicide are retrospective with up to an 18 month lag due to the time required for coronial processes. Annual statistics on suicide are published through the ABS Causes of Death (cat. no. 3303.0) publication and the Productivity Commission's Report on Government Services. More detailed information is available through the ABS publication, Suicides, Australia (cat. no. 3309.0). These statistics provide comparisons across jurisdictions and are the most robust comparisons over time, with age-standardised rates.

Department of the Attorney General The Western Australia Department of the Attorney General's Coroner's Office prepares a quarterly report on suicides statistics that is sent to the Minister for Mental Health. This report, of which the Mental Health Commission receives a copy, contains statistics sourced from the National Coronial Information Service (NCIS) and provides cases where a death has been reported to the Coroner's Office as a suspected suicide or where a coroner has made a final determination of a finding of suicide. Data is provided by Aboriginality, region and age group (under and over 25 years).

These statistics are more timely than those sourced through the ABS, and include the number of suspected suicides. They include useful breakdowns such as Aboriginality by broad age group and region. However, the current data management systems at the Coroner's Office limit the ability to undertake more detailed analysis on other factors relating to the suicide. This is a priority area for improvement.

Epidemiology Branch, Department of Health Western Australia The Department of Health's Epidemiology Branch has access to the unit record data on suicides from the ABS and is able to derive additional statistics for specified demographics.

The data can be extracted according to different criteria which enable more comprehensive analyses and linkages between data sets that are not available in national publications. However, there are time delays for this data as the Department of Health receives the file from ABS are it releases its annual Causes of Death publication.

IMPLEMENTATION OF SUICIDE PREVENTION 2020

Governance structure

The Ministerial Council for Suicide Prevention will provide expert advice to the Minister for Mental Health and Mental Health Commissioner. The Council will provide strategic advice on suicide prevention initiatives to:

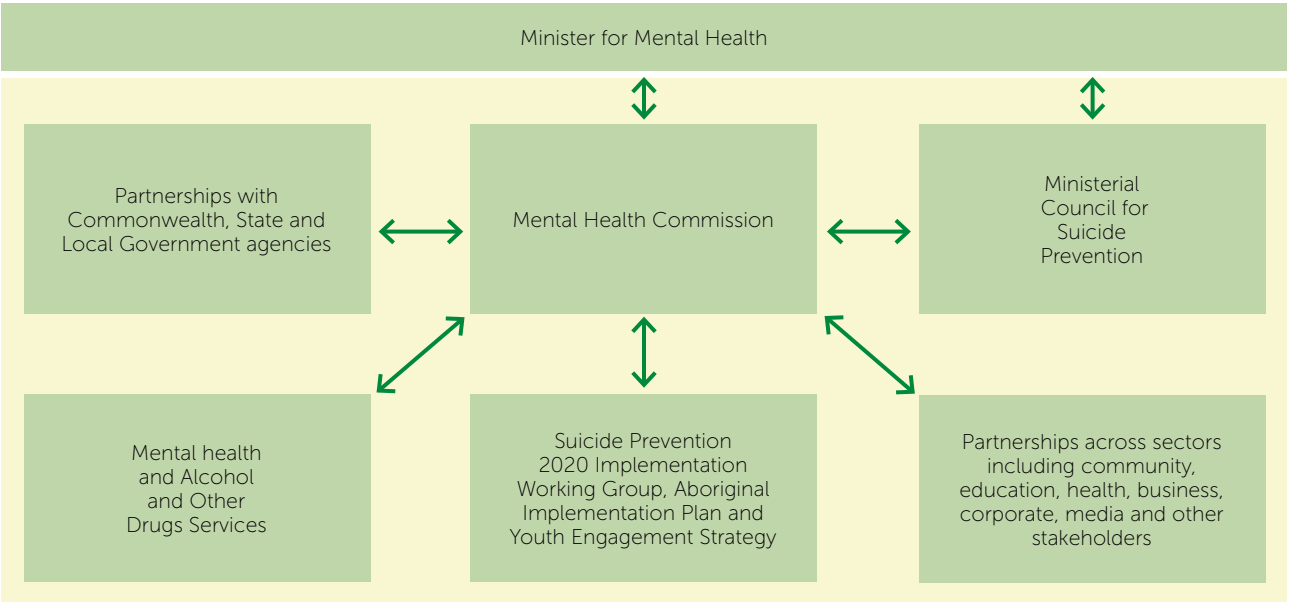
- Better understand the problem of suicide;
- Disseminate evidence-based research and promote best practice responses;
- Enhance community strength and resilience;
- Increase community understanding of suicide; and
- Support capacity building to recognise and respond to suicide risk.

The Mental Health Commission has dedicated suicide prevention staff to leverage partnerships and investment and undertake policy, research and service development, as well as providing executive support to the Council.

The Mental Health Commission will develop the overall Implementation Plan for *Suicide Prevention 2020* and a dedicated Aboriginal Suicide Prevention Implementation Plan. Further, a youth engagement strategy will be established to ensure longer term outcomes by informing and involving young people across Western Australia and at a local level.

The Mental Health Commission will lead the implementation of *Suicide Prevention 2020* and related initiatives through inter-sectoral partnerships with local, state and Commonwealth Government agencies, community managed services and corporate organisations. The Mental Health Commission will also oversee the commissioning of services and small grants, and ensure effective communications, monitoring of programs and facilitation of evaluations.

To assist with ensuring coordinated and effective implementation of actions, the Mental Health Commission will establish a Suicide Prevention Implementation Working Group with input from a wide range of stakeholders and people with lived experience. This group will closely align with the governance framework established for the *Mental Health and Alcohol and Other Drugs Services Plan 2015-2025*.



BUILDING RESILIENCE ACROSS LIFE STAGES AND PRIORITY ACTIONS: EXAMPLE TEMPLATE FOR ORGANISATIONS TO ADAPT

There are a number of protective factors we develop throughout our lives. Suicide prevention actions in Western Australia will be addressed by a range of sectors to improve mental health and reduce suicide risk factors throughout the life course.

Targeted protective factors across life stages		
	Parents, perinatal and early years	School age
Families and communities have a vital role in building protective factors	• Family physical, emotional and psychological wellbeing • Caring and healthy relationships • Effective parenting and coping skills • Extended family and community support • Positive early childhood development and healthy attatchment	• Development of positive self esteem, communication and coping skills • Supportive relationships with family, peers and the wider community • Engagement in school, education and recreation activities • Development of self-worth, personal safety and healthy boundaries • Significant adult who is a positive role model
Priority actions to strengthen vulnerable individuals, families and communities		
1. **Priority Action 1:** Greater public awareness and united action across the community		
2. **Priority Action 2:** Local support and community prevention across the lifespan		
3. **Priority Action 3:** Coordinated and targeted responses for high-risk groups		
4. **Priority Action 4:** Shared responsibility across government, private and non-government sectors to build mentally healthy workplaces		
5. **Priority Action 5:** Increased suicide prevention training		
6. **Priority Action 6:** Timely data and evidence to improve responses and services		

Young adults	Family building and working age	Older age
• Ability to care for their own health and wellbeing and access support • Capacity to create satisfying personal and social relationships • Skills to cope with difficult emotions or problems • Development of skills to live independently and reach personal goals • Successful transition from school to work or study	• Strong identity, with a sense of purpose and agency over one's life • Activities and support for ongoing wellbeing and health or healing • Maintaining deeper family and social relationships and responsibilities • Opportunities to make a meaningful contribution or show leadership at home, work or in the community • Stable finances, employment and safe housing	• Staying mentally, physically and socially active • Opportunities to contribute and be valued by family and the community • Managing health issues and accessing services • Positive transition from work and family responsibilities into retirement • Financial security, safe housing and social support • Drawing on own beliefs, values and wisdom to deal with change or loss

APPENDIX A: CURRENT MENTAL HEALTH REFORM

Western Australian mental health reform

Suicide Prevention 2020 will build on the significant reforms currently underway to improve the mental health system and outcomes for all Western Australians. Over the past five years there have been a number of significant developments and influences that have occurred nationally and within Western Australia that have assisted in improving and reforming mental health which in turn, has created an enhanced environment for reducing suicide. Significant developments and initiatives include but are not confined to:

Mental Health Commission

The State Government commenced the reform process by establishing a dedicated Mental Health Commission in 2010. The Mental Health Commission is focused on improving access to inpatient and community-based services that deliver recovery-focused care and treat people with mental illness, drug or alcohol problems and their families and carers with respect and dignity.

In 2014/15 the State Budget provided total funding of a record $791.6 million for mental health and drug and alcohol services. This represents a 45% or $245.3 million increase in investment since the first full year of operation of the Mental Health Commission.

The Mental Health Commission directly provides approximately $1.7 million for suicide prevention, early intervention, counselling and crisis support services. This is delivered through a range of specialist non-government organisations including Lifeline WA, beyondblue, Youth Focus, Perth Central and East Metro Medicare Local, The Samaritans and the Freedom Centre.

Statewide Aboriginal Mental Health Service

The State Government has provided a further $29.1 million over 2014/15 to 2016/17 to consolidate the Statewide Aboriginal Mental Health Service to provide a range of treatment and support services to Aboriginal people with severe and persistent mental illness. The service aims to improve community support, enhance treatment and discharge planning, and provide clinical services for Aboriginal people through an increased Aboriginal workforce.

Early evaluations have shown positive mental health outcomes and evidence of service improvement.

An Aboriginal consumer and carer advisory group has been established to enhance culturally secure decision making. Aboriginal people will be mentored to participate in health committees and provide input into cultural and clinical issues.

Mental Health Act 2014

Modernisation of mental health legislation is a key element of the State's mental health reform agenda. The *Mental Health Act 2014* (the Act) was passed by the Western Australian Parliament in 2014. The Act provides new rights and protections for people experiencing mental illness and promotes recovery-oriented practice within mental health services. It recognises the important roles of families and carers by providing rights to information and involvement. The Act also provides increased certainty and clarity for clinicians and builds on existing best clinical practice.

Stokes Review 2012

An important catalyst in reforming the mental health system was the commissioning by the State Government of key studies to identify and critically explore and analyse mental health issues. One of these key studies is the 2012 report by Professor Bryant Stokes, *Review of the admission or referral to and the discharge and transfer practices of public mental health facilities/services in Western Australia* (the Stokes Review). The Review provided 117 recommendations to improve the system, focused largely on public specialist mental health

services but also indicating the need for sector-wide change. The State Government has made a written response to the Review committing to implement the recommendations and significant improvements are well underway.

Amalgamation of the Mental Health Commission and the Drug and Alcohol Office

One of the recommendations from the Stokes Review is the need for improved collaboration between the mental health, alcohol and other drug sectors to coordinate care for people with co-occurring mental health, alcohol and other drug problems.

In April 2013, the Minister for Mental Health announced the amalgamation of the Drug and Alcohol Office and the Mental Health Commission. The aim is to better integrate the State's network of prevention, treatment, community support, professional education and training and research activities across both areas. This improved coordination of services will provide better support to people with co-occurring issues and enhance suicide prevention programs for those most at-risk across the State.

Ten year services plan

The Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015-2025 (the Plan) has been developed by the Mental Health Commission, Department of Health and Drug and Alcohol Office in response to an urgent need to reduce the incidence and negative impacts of mental health, alcohol and other drugs problems in the Western Australian community.

The Plan outlines a mental health, alcohol and other drug service system for Western Australia that prevents and reduces mental health problems, suicide and suicide attempts and promotes positive mental health. It also prevents and reduces the adverse impacts of alcohol and other drugs. It enables everyone to work together to encourage and support people who experience mental health, alcohol and other drug problems to stay in the community, out of hospital and live a meaningful life.

The Plan is based on agreed national models and frameworks with system changes to be progressed over the next ten years. Priorities are separated into the sections of prevention and mental health promotion. Community support services. Community treatment services. Community bed based services; hospital based services. Specialised services. Forensic services and system improvement and supporting change.

In the Plan, each section provides information regarding services, programs and funding for the current system, the service requirement in 2025 and what strategies and actions will be implemented to achieve the required mix of services.

The Plan will strengthen collaborative action and re-focus investment in initiatives that promote positive mental health and prevent harm to individuals through mental ill health, suicide and harmful alcohol and other drug use. Strategies focus on expanding evidence-based alcohol and other drug prevention programs; reducing stigma; establishing infant, child and young people best practice prevention programs; reducing suicide; and addressing physical health problems.

Early priorities for prevention include:

- Legislate in response to the rapid emergence of new psychoactive substances;
- Increased prevention workforce;
- Improved access to online support; and
- Expanded public education campaigns promoting positive mental health and targeting harmful alcohol and other drug use – including school-based education campaigns.

Mental Health Network

Health Networks in Western Australia were established after a major review of health services in 2003 with the aim of enabling a new focus across all clinical disciplines towards prevention of illness and injury and maintenance of health.

The major functions of Health Networks are to plan and develop:

- Evidence-based policy and practice;
- Statewide clinical governance;
- Transformational leadership and engagement;
- Strategic partnerships; and
- Evaluation and monitoring systems

The Mental Health Network was launched in October 2014. It is a partnership between Western Australia Health and the Mental Health Commission and provides a forum for consumers, carers, clinicians and stakeholders to participate in decisions about mental health planning and development.

Anyone with an interest in improving health in Western Australia can join a network including consumers, doctors, nurses, midwives, allied health professionals, carers and policy makers.

Commonwealth mental health and suicide prevention initiatives

Suicide prevention is a shared State and Commonwealth responsibility. It is essential that the State and Commonwealth Governments collaborate on suicide prevention and related initiatives to achieve the best possible outcomes for communities; ensure service coordination and effective use of resources; and reduce duplication and confusion for individuals and families navigating the health system and other services. The Commonwealth has also engaged with Western Australia in a number of National Partnership Agreements such as the National Perinatal Depression Initiative and the Supporting National Mental Health Reform.

The National Mental Health Commission

The Commonwealth Government established the National Mental Health Commission (NMHC) in 2012. The NMHC produces an annual *National Report Card on Mental Health and Suicide Prevention* (the Report Card). The Report Card measures and provides transparency on how systems providing support and care are performing for mental health consumers, their families and carers, service providers, governments and other stakeholders. The NMHC takes a whole of life focus and reports across several domains including physical health and well-being, social support, housing, education and employment.

The National Suicide Prevention Strategy

The National Suicide Prevention Strategy was launched in 1999 and established the *Living is for Everyone* (LIFE) Framework in 2007, which remains the current national plan to prevent suicide and build community resilience across the Australian population.

The main objectives of the National Suicide Prevention Strategy are to:

- Build individual resilience and the capacity for self-help;
- Improve community strength, resilience and capacity in suicide prevention;
- Provide targeted suicide prevention activities;
- Implement standards and quality in suicide prevention;
- Take a coordinated approach to suicide prevention; and
- Improve the evidence base and understanding of suicide prevention.

National Aboriginal and Torres Strait Islander Suicide Prevention Strategy

Australia's first *National Aboriginal and Torres Strait Islander Suicide Prevention Strategy* was released in May 2013. The strategy highlights the importance of cultural continuity as a protective factor against suicide risk and emphasises Aboriginal and Torres Strait Islander peoples' holistic view of mental health, physical, cultural and spiritual health. It focuses on 'upstream' prevention efforts that build community, family and individual resilience. The strategy action areas are aligned with the LIFE Framework.

Taking Action to Tackle Suicide

In response to recommendations made by the Senate *The Commonwealth Response to The Hidden Toll: Suicide in Australia* was tabled in Parliament on 24 November 2010 and included details of the Taking Action to Tackle Suicide (TATS) package. The TATS package provides further support for suicide prevention through universal and population-wide approaches and through community led responses. The TATS package was comprised of the following four areas:

1. More frontline services and support for those at greatest risk of suicide;
2. More services to prevent suicide and boost crisis intervention services;
3. Target men who are at greatest risk of suicide; and
4. Programs to promote good mental health and resilience in young people.

Commonwealth funding and reviews

The National Suicide Prevention Program provides dedicated Commonwealth funding for suicide prevention activities. There are currently 49 projects under this program that have recently been evaluated and are funded until 30 June 2015. Funding for the TATS package totaling $292.4 million for the period 2011/12 to 2015/16 ends on 30 June 2016.

In relation to alcohol and other drugs, a Review of the Drug and Alcohol Treatment Services Sector project was commissioned by the Commonwealth in 2013 and findings are expected to be available in 2015. This project aims to clarify Australian:

- Treatment funding;
- Current and future service needs;
- The gap between met and unmet demand; and
- Provide recommendations to inform the Commonwealth Government's planning and funding processes.[58]

The findings of the Review are expected to identify ways for governments to work more collaboratively and better plan for delivery of alcohol and other drug services and improve treatment outcomes.[59]

A similar but separate National Review of Mental Health Programs has been initiated by the National Mental Health Commission at the request of the Commonwealth Government. Both reviews have potential to impact on future planning and implementation of mental health, alcohol and other drug services.

The StandBy Response Service is a suicide postvention service for people who have lost a loved one to suicide funded by the Australian Government. The focus of the service is to provide practical assistance with ongoing support and follow-up for users of the service. StandBy aims to build on existing community strengths to rapidly build after-suicide postvention capacity. Currently StandBy has three sites in Western Australia located in the East and West Kimberley and in the Pilbara. In 2014 StandBy supported the Bunbury region to respond to increased youth suicides, by providing bereavement counselling, delivering training to local services, and coordinating local stakeholders to develop a referral pathway to services and Bunbury postvention plan.

APPENDIX B: SUICIDE PREVENTION EVIDENCE-BASED MODELS

International best practice

Suicide Prevention 2020 draws on the World Health Organization intervention approaches and key strategic actions in the 2014 report *Preventing suicide: A global imperative* to:

- Engage key stakeholders;
- Reduce access to means;
- Conduct surveillance and improve data quality;
- Raise awareness;
- Engage the media;
- Mobilise the health system and train health workers;
- Change attitudes and beliefs;
- Conduct evaluation and research; and
- Develop and implement a comprehensive national suicide prevention strategy.

Elements of the Optimizing Suicide Prevention Intervention (OSPI) program that was successfully implemented in Europe have also been adopted. The OSPI model was based on a German depression intervention that found improvement in depression awareness and treatment led to a reduction in suicidal behaviour on a population basis. It was rigorously evaluated and demonstrated a 24% reduction in the number of suicidal acts compared to the baseline year. The reduction was even more pronounced (-53%) when looking only at the five most drastic suicide attempt methods.[60]

The OSPI model comprises a five level intervention: [60, 61]

1. Training and practice support for General Practitioners in detecting and treating depression;
2. General public awareness campaign including information on depression and stigma reduction;
3. Training sessions on depression and suicidality for community facilitators such as priests, pharmacists, social workers, aged-care workers, teachers and journalists who are gatekeepers in a position to direct vulnerable people to effective treatment;
4. Offers of support for high-risk groups (people who have previously attempted suicide or self-harm) and their families, with establishment of help lines and self-help activities; and
5. Restricting access to lethal means.

Stigma associated with mental illness can be a significant barrier to people at risk accessing help. International research shows that successful stigma reduction approaches are peer based and include contact and education by people who have lived experience of severe mental illness and are working towards recovery.[61]

Australian collaborative approaches

National Coalition for Suicide Prevention

The goal of the National Coalition for Suicide Prevention (the Coalition) is a 50% reduction in suicides in Australia by 2023. This includes halving the number of suicide attempts.

The Coalition has agreed to adopt the principles of collective impact. This will require suicide prevention and mental health sectors, as well as business and government, to commit to a common agenda, shared goals and measures and a consistent reporting framework.

Collective impact has shown great promise in United States communities addressing intractable social problems and members of the Coalition firmly believe that it has the potential to make a difference in suicide prevention in Australia. Similarly the most successful initiatives in the United States have been those that engaged all three sectors – community – businesses (small, medium and large) – and government (local, state and federal). At its heart, collective impact enables us to solve challenging social problems with the resources we already have at our disposal.

It identified that a systems approach to suicide prevention produces the best outcomes. This requires that key initiatives are implemented locally; with the involvement of medical, health and community agencies; and together at the same time.[9]

Informed by comprehensive research by the Black Dog Institute, the Coalition asserts that the strongest evidence based initiatives for suicide prevention are:

1. Reducing access to lethal means of suicide;
2. Responsible reporting by the media;
3. School based peer support and screening;
4. Gatekeeper training in schools and closed organisations (e.g. military and prisons);
5. Training of front line staff every three years;
6. Training of general practitioners in detecting and dealing with risk;
7. High quality treatment for those with mental illness, including cognitive behaviour therapy, dialectical behaviour therapy and online treatment; and
8. Appropriate and continuing care once people leave emergency departments:
    - 24/7 call out emergency teams experienced in child/adolescent suicide prevention
    - Crisis-call lines and chat services for emergency callers
    - Assertive outreach for those in Emergency Departments and discharged including those hard to engage with
    - E-health services of web programs through the internet.[9]

REFERENCE LIST

1. Western Australian State Coroner. unpublished Quarterly Report of Suspected Suicides in Western Australia. 2013.
2. World Health Organization. Preventing Suicide: A global imperative. World Health Organization, 2014.
3. Ombudsman Western Australia. Investigation into ways that State government departments and authorities can prevent or reduce suicide by young people. In: Investigations TPCfA, editor. 2014.
4. Australian Bureau of Statistics. Causes of Death, Australia, 2012. 2014 cat no. 3303.0.
5. KPMG Health Economics for Menslink. The economic cost of suicide in Australia Menslink, 2013.
6. U.S. Surgeon General, National Action Alliance for Suicide Prevention. 2012 National Strategy for Suicide Prevention: Goals and Objectives for Action. Washington, D.C.: US Department of Health & Human Services, 2012.
7. Mental Health Commission Western Australia. Mental Health 2020: Making it personal and everybody's business. Perth, Western Australia: Government of Western Australia, 2010.
8. World Health Organization, Calouste Gulbenkian Foundation. Social determinants of mental health. Geneva: World Health Organization, 2014.
9. Suicide Prevention Australia. Discussion Paper: One World Connected: An assessment of Australia's progress in suicide prevention. Sydney, NSW: Suicide Prevention Australia, 2014.
10. Steering Committee for the Review of Government Service Provision. Report on Government Services 2014. Canberra, ACT: Productivity Commission, Commonwealth of Australia, 2014.
11. Wasserman D. Suicide: an unnecessary death: Taylor & Francis; 2001.
12. Connor K, Langley J, Tomaszewski K, Conwell Y. Injury hospitalisation and risks for subsequent self-injury and suicide: A national study from New Zealand. American Journal of Public Health. 2003;93(7):1128-31.
13. Mann JJ, Apter A, Bertolote J, Beautrais A, Currier D, Haas A, et al. Suicide prevention strategies: a systematic review. Jama. 2005;294(16):2064-74.
14. Joiner TE, Van Orden KA, Witte TK, Rudd MD. The interpersonal theory of suicide: Guidance for working with suicidal clients: American Psychological Association; 2009.
15. Suicide Prevention Australia. Position Statement - Mental Illness and Suicide. Sydney, NSW: Suicide Prevention Australia, 2009.
16. Martin G, Swannell S, Harrison J, Hazell P, Taylor A. The Australian National Epidemiological Study of Self-Injury (ANESSI). Centre for Suicide Prevention Studies, The University of Queensland, 2010 1.
17. Australian Bureau of Statistics. National Survey of Mental Health and Wellbeing: Summary of Results, 2007. 2007 cat no. 4326.0.
18. Telethon Institute for Child Health Research. Western Australia Coroner's Database on Suicide, unpublished data. 2009.
19. Mindrame National Media Initiative. Facts and stats about suicide in Australia 2014 [cited 2014 12 November]. Available from: http://www.mindframe-media.info/for-media/reporting-suicide/facts-and-stats.
20. Ramstedt M. Alcohol and suicide at the population level-the Canadian experience. Drug and alcohol review. 2005;24(3):203-8.
21. Landberg J. Alcohol and suicide in eastern Europe. Drug and Alcohol Review. 2008;27(4):361-73.
22. Drug and Alcohol Office. Alcohol and Other Drug Indicators Report - North Metro Region 2006-2010. Government of Western Australia, 2013 Contract No.: 1.
23. Harris EC, Barraclough B. Suicide as an outcome for mental disorders. A meta-analysis. The British Journal of Psychiatry. 1997;170(3):205-28.
24. Beautrais AL, Joyce PR, Mulder RT. Cannabis abuse and serious suicide attempts. Addiction. 1999;94(8):1155-64.
25. Hunt IM, Kapur N, Robinson J, Shaw J, Flynn S, Bailey H, et al. Suicide within 12 months of mental health service contact in different age and diagnostic groups: National clinical survey. The British Journal of Psychiatry. 2006;188(2):135-42.
26. Joiner T. Why people die by suicide: Harvard University Press; 2009.
27. Youth Focus. Families are the strength of our nation: Including families in suicide prevention. 2014.
28. Shiner M, Scourfield J, Fincham B, Langer S. When things fall apart: Gender and suicide across the life-course. Social Science & Medicine. 2009;69(5):738-46.
29. Chaudron LH, Caine ED. Suicide among women: a critical review. Journal of the American Medical Women's Association (1972). 2003;59(2):125-34.
30. Post and Antenatal Depression Association Inc. Risks of Postnatal Depression 2010 [cited 2014 25 November]. Available from: http://www.panda.org.au/practical-information/about-postnatal-depression/31-risks-of-postnatal-depression.

31. Slade T, Johnston A, Teesson M, Whiteford H, Burgess P, Pirkis J, et al. The mental health of Australians 2: report on the 2007 National Survey of Mental Health and Wellbeing. Canberra, ACT: Department of Health and Ageing, 2009.

32. Suicide Prevention Australia. Work and Suicide Prevention: Position Statement. Sydney, NSW: Suicide Prevention Australia, 2014.

33. Australian Bureau of Statistics. Suicides, Australia. 2010 cat no. 3309.0.

34. beyondblue, PricewaterhouseCoopers. Creating a mentally healthy workplace: return on investment analysis 2014 [cited 2014 12 November]. Available from: http://www.headsup.org.au/docs/default-source/resources/beyondblue_workplaceroi_finalreport_may-2014.pdf.

35. HM Government. Preventing suicide in England: A cross-government outcomes strategy to save lives. In: Health Do, editor. London, UK: Department of Health; 2012.

36. Suicide Prevention Australia. Chronic Illness, Chronic Pain and Suicide Prevention Position Statement. Sydney, NSW: Suicide Prevention Australia, 2012.

37. SANE Australia. Research Bulletin 11: Suicide, self-harm and mental illness 2010 [cited 2014 12 November]. Available from: http://www.sane.org/images/stories/information/research/rb11.pdf.

38. Wilcox HC, Kuramoto SJ, Lichtenstein P, Långström N, Brent DA, Runeson B. Psychiatric morbidity, violent crime, and suicide among children and adolescents exposed to parental death. Journal of the American Academy of Child & Adolescent Psychiatry. 2010;49(5):514-23.

39. Hung N, Rabin L. Comprehending Childhgood Bereavement by Parental Suicide: A Critical Review on Research Outcomes, Grief Processes and Interventions. Death Studies. 2009;33(9):781-814.

40. Ratnarajah D, Schofield M. Impact of Parental Suicide and its Aftermath: A review. Journal of Family Studies. 2007;78:85-9.

41. Jakobsen I, Christiansen E. Young People's risk of suicide attempts in relation to parental death: a population-based register study. Journal of Child Psychology and Psychiatry. 2011;52(2):176-81.

42. Dudgeon P, Walker R, Scrine C, Shepherd C, Calma T, Ring I. Effective strategies to strengthen the mental health and wellbeing of Aboriginal and Torres Strait Islander people. Issues paper no 12 produced for Closing the Gap Clearinghouse. 2014.

43. Tatz C. Aboriginal suicide is different: A portrait of life and self-destruction. Canberra, ACT: Aboriginal Studies Press; 2005. xxv p.

44. Department of Communities. Principles for providing postvention responses to individuals, families and communities following a suicide death. Brisbane, Queensland: Queensland Government, 2008.

45. beyondblue. Depression and anxiety in gay, lesbian, bisexual, transgender and intersex people (GLBTI) [Factsheet] 2014 [cited 2014 12 November]. Available from: https://www.bspg.com.au/dam/bsg/product?client=BEYONDBLUE&prodid=BL/0648&type=file.

46. Rosenstreich G. LGBTI People: Mental Health and Suicide. Revised 2nd Edition. Sydney, New South Wales: National LGBTI Health Alliance, 2013.

47. Department of Health Western Australia. HealthTracks Reporting: Alcohol and other drug hospitalisations by Health Region 2007-2011. Epidemiology Branch System Policy and Planning, Department of Health Western Australia in collaboration with the CRC for Spatial Information, 2014.

48. Deloitte Consulting for the Department of Justice - Corrections Victoria. Victorian Prisoner Health Study. Melbourne, Victoria: Government of Victoria, 2003 Contract No.: 12 November.

49. Ansari G, Chipps J, Stewart G. Suicide in New South Wales: The NSW Suicide Data Report. New South Wales Public Health Bulletin. 2001;12(3):80-4.

50. Australian Institute of Health and Welfare. A snapshot of men's health in regional and remote Australia. Rural health series no. 11. Canberra, ACT: Australian Government, 2010 cat no. PHE 120.

51. Women's Health Victoria. Women and Suicide Melbourne, Victoria: 2011.

52. Mental Health Commission Western Australia. Understanding stigma associated with mental illness and creating behavioural changes. Perth, Western Australia: Government of Western Australia,, 2012.

53. SANE Australia. A life without stigma: A SANE Report. SANE Australia, 2013.

54. Pross C. Burnout, vicarious traumatization and its prevention. Torture. 2006;16(1):1-9.

55. Gordon Jr, Robert S. An operational classification of disease prevention. Public health reports. 1983;98(2):107.

56. Mrazek PJ, Haggerty RJ. Reducing Risks for Mental Disorders:: Frontiers for Preventive Intervention Research. Sciences NAo, editor. USA: National Academies Press; 1994.

57. Statistics ABS. Australian Social Trends, Jun 2011. 2011 cat no. 4102.0

58. University of New South Wales. Review of the drug and alcohol prevention and treatment services sector [webpage] 2014 [cited 2014 13 November]. Available from: http://dpmp.unsw.edu.au/project/review.

59. Department of Health. Substance Misuse Service Delivery Grants Fund. Australian Government,, 2013 Contract No.: 12 November.

60. Hegerl U, Althaus D, Schmidtke A, Niklewski G. The alliance against depression: 2-year evaluation of a community-based intervention to reduce suicidality. Psychological medicine. 2006;36(09):1225-33.

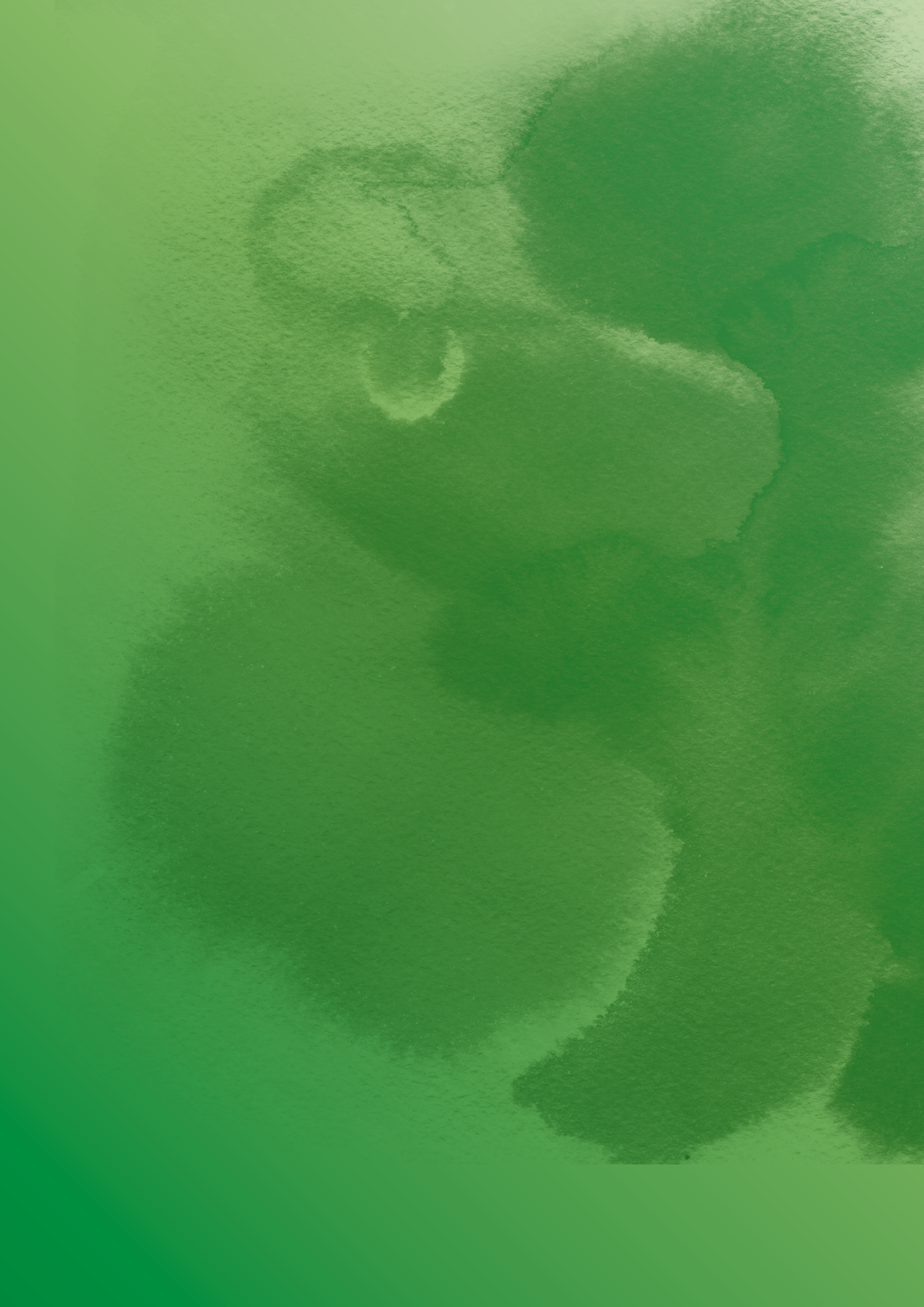
61. Corrigan PW, Morris SB, Michaels PJ, Rafacz JD, Rüsch N. Challenging the public stigma of mental illness: a meta-analysis of outcome studies. Psychiatric Services. 2012;63(10):963-73.

SUICIDE PREVENTION 2020 PROVIDES THE FRAMEWORK AND GOVERNANCE STRUCTURE FOR SUICIDE PREVENTION IN WESTERN AUSTRALIA.

HOWEVER, IT IS UP TO INDIVIDUALS, COMMUNITY, GOVERNMENT AND BUSINESS TO IMPLEMENT THE CHANGES AND DIRECTIONS NEEDED TO CREATE LASTING CHANGE.

SUICIDE IS PREVENTABLE, TOGETHER WE CAN SAVE LIVES.

Hon Helen Morton MLC
Minister for Mental Health



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