



Government of **Western Australia**
Mental Health Commission



Western Australian Suicide Prevention Action Plan 2021 - 2025

Consultative draft October 2019



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This resource was prepared by:

Mental Health Commission
GPO Box X2299
Perth Business Centre WA 6847

Feedback

Any feedback related to this document should be emailed to:
SPActionPlan2025@mhc.wa.gov.au

Acknowledgements

We remember those we have lost to suicide, and their families, friends, loved ones and others affected by their deaths.

We respectfully acknowledge and pay our respects to Aboriginal and Torres Strait Islander Elders, past, present and emerging, and acknowledge the diversity and strength of Aboriginal and Torres Strait Islander people and communities today.

The Western Australian Suicide Prevention Action Plan 2021 – 2025 (Suicide Prevention Action Plan 2025) is the result of contributions from many organisations and individuals from across the Western Australian community. These include:

Members of the steering committee, who provided content expertise and insight to further represent the voices of vulnerable populations and academic experts. Suicide prevention coordinators who were instrumental in bringing together service providers, local government, non-government, private sector, and community members from across the state, to ensure their needs were voiced.

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We sincerely thank the community and everyone who had any involvement with or contributed to the state-wide engagement and shared their experiences and for their dedicated commitment to address suicide in Western Australia.

Accessibility

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Introduction



Introduction

Everyone has a role in suicide prevention. Reducing the rate and impact of suicide in our communities requires a whole-of-population commitment; it is not something any single agency, level of government or community can do alone. The impact of suicide is far-reaching and long-lasting; it has a devastating effect on families, friends and services which ripples throughout communities. A 2016 Australian report indicates that 89% of Australians knew someone who had attempted suicide, and that 85% knew someone who had died by suicide. For every person who takes their life, more than 135 people experience intense grief or are otherwise affected.

In 2018, 3,046 people died by suicide in Australia. For every suicide death as many as 25 people will attempt suicide, meaning 78,000 Australian's require appropriate, timely and critical care to support their recovery each year. Suicide was estimated to account for 108,035 years of potential life lost (YPLL) potential years of life lost for all persons in Australia in 2017 .

In 2018, 383 individuals died by suicide in Western Australia (WA); this is more than one person a day. WA had the third-highest rate of suicide of all Australian states and

territories (14.7 deaths per 100,000 people) its rate has been consistently higher than the national average (12.1 deaths per 100,000 people) since 2008 .

Between 2014 and 2018, WA had the highest age-standardised rate of suicide among Aboriginal people (37.9 deaths per 100,000 people). This was considerably higher than the national average for Aboriginal people over the same period (23.7 deaths per 100,000).

Suicidal behaviour is complex; many factors and multiple pathways may lead a person to attempt to take their life. In the quest for effective suicide prevention strategies, no single activity stands out above others. A range of strategies focusing on lowering the risks and increasing the protective elements is essential. It is imperative to remember that suicide can be prevented if individuals, communities, government and non-government sectors work together and implement ongoing evidence-based, coordinated, multilevelled activity that supports the creation of a community that experiences optimal mental health and wellbeing.

The Western Australian Suicide Prevention Action Plan 2021 - 2025 (Suicide Prevention Action Plan 2025) aims to create a platform for all Western Australians to be better educated on suicidal behaviours, and

understand how we as a community can support those vulnerable to suicide and self-harm, and those affected by suicide.

Building on existing programs and aligned with State and Commonwealth policy directions, the Suicide Prevention Action Plan 2025 supports the WA Government's existing commitments to tackling the complex issues of suicide and sets the direction for future action. It brings the voices of the community and the sector together to provide understanding and guidance for individuals, communities, private and non-government organisations and government.

Western Australia statistics

Suicide is the leading cause of death among people aged 14 – 44 years.

Aboriginal people have a rate of suicide three times higher non-Aboriginal people in WA.

15.5% of LGBTI young people in the Growing up Queer study reported attempting suicide at some point in their life.

48.1% of young transgender people in the Trans Pathways study reported attempting suicide at some point in their life.

Problems related to substance use were present in 29.4% of deaths by suicide in Australia in 2018.

Mood disorders, including depression, were present in 43.9% of deaths by suicide in Australia in 2018.

¹ Reference to Aboriginal people throughout this document respectfully are inclusive of the Torres Strait Islanders.

A note about language when talking about suicide

Please remember that suicide is a complex issue and arises from an interaction between many circumstances in a person's life. Using safe and inclusive language is helpful when talking about suicide.

Don't say	Why	Do say
'unsuccessful suicide'	So as to not glamorise or normalise a suicide attempt	'non-fatal' or 'made an attempt on his/her life'
'successful suicide'	So as to not present suicide as a desired outcome	'took their life' or 'ended their own life'
'committed' or 'commit suicide'	So as to avoid the association between suicide and 'crime' or 'sin'	'died by suicide' or 'deaths by suicide'
'suicide epidemic'	To avoid sensationalism and inaccuracy	'concerning rates of suicide' or 'number of deaths'

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The Western Australian approach



The Western Australian approach

Background

The WA State Government has so far been responsible for two suicide prevention strategies, covering the period from 2009 to the present.

The Suicide Prevention Strategy - One Life, which ran from 2009 to 2013, received funding of \$24 million. It was developed from an analysis of almost 20 years of data on suicide and self-harm in Western Australia, a comprehensive literature review of suicide prevention research, and an extensive state-wide consultation process. It was also aligned with the former National Suicide Prevention Strategy: Living is for Everyone (LIFE).

One Life was succeeded by Suicide Prevention 2020: together we can save lives (Suicide Prevention 2020), which received funding of \$33.9 million between May 2015 and December 2020. Suicide Prevention 2020 was organised under six key action areas and provided services and activities to at-risk populations in multiple locations across the state.

During the implementation of Suicide Prevention 2020, there were significant developments in the Australian and international suicide prevention literature and research. In addition, the Commonwealth and State and Territory Governments committed to a more coordinated approach to address suicide prevention across Australia.

Current research supports implementing multiple strategies, delivered simultaneously across a range of areas which is referred to as a systems-based approach.

Systems-based approaches that have emerged since the launch of Suicide Prevention 2020 include the Alliance Against Depression (AAD) model, the LifeSpan Integrated Suicide Prevention (LifeSpan) model, and the Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project (ATSISPEP) framework.

To ensure consistency and a focus on a systems-based approach to address the suicide rates, the

National Mental Health Commission (NMHC) supported the development of the Fifth National Mental Health and Suicide Prevention Plan (the Fifth Plan). The Fifth Plan has been endorsed by the Council of Australian Governments (COAG) Health Council and sets a clear direction for coordinated action by the Commonwealth, state and territory governments. The Fifth Plan also acknowledges the unique challenges faced by Aboriginal people with the recommendation to develop a National Aboriginal and Torres Strait Islander Suicide Prevention and Implementation Plan. The Fifth plan outlines a commitment from government to develop a National Suicide Prevention Implementation Strategy (NSPIS), which is currently under development.

The Suicide Prevention Action Plan 2025 was developed within a framework that uses a whole-of-population approach and closely aligns with the Fifth Plan, the NSPIS and some of the systems-based approaches mentioned above.

The Suicide Prevention Action Plan 2025 Framework (appendix One) has four major streams: prevention, intervention, postvention and Aboriginal people. Table 1 shows the Suicide Prevention Action Plan 2025 approach across the suicide prevention continuum.

Suicide Prevention Action Plan 2025

The Suicide Prevention Action Plan 2025 aims to build on the work of the previous strategies and the state's investment of approximately \$55 million over the past 10 years.

It is intended to support in part the implementation of State Government strategic documents such as:

- The Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015-2025;
- Gayaa Dhuwi (Proud Spirit) Declaration;
- The State Public Health Plan for Western Australia.
- It also expands on the State Government's continued

commitment to improving the mental health and wellbeing of the community, and addresses suicide-related findings and recommendations of several reports, including the WA State Coroner's Inquest into the deaths of 13 children and young people in the Kimberley and the 2016 Message Stick Inquiry into Aboriginal youth suicide in remote areas.

The Action Plan, was designed in consultation with the community, government, non-government organisations, and the mental health sector. It was developed using the most current data, research, evaluation and reports, and the expertise of various working and steering groups.

² In this document, 'vulnerable populations' refers to those populations who have a higher risk of suicide and suicidal behaviour. These include: Aboriginal people; persons who have experienced abuse, trauma, conflict or disaster; refugees and migrants; prisoners and others in contact with the justice system; lesbian, gay, bisexual, transgender and intersex persons (LGBTI); frontline workers, individuals who have had a previous attempt and people suicide bereaved.

It has taken into consideration the voices of vulnerable populations as well as the lived experiences of those who have been bereaved by suicide, and those who have experienced being suicidal.

The Suicide Prevention Action Plan 2025 provides the framework for a coordinated approach to address suicide prevention activity in Western Australia from 2021 to 2025 under the four priority areas of prevention,

intervention, postvention and Aboriginal.

It can be used by state and local government agencies, non-government and private organisations and communities to help identify their role in suicide prevention and guide the investment, development, implementation and evaluation of suicide prevention activities.

The Suicide Prevention Action Plan 2025 is an action-orientated and dynamic document which recognises the need for a mix of place based and state-wide activities. It takes into account the complexities of WA, including the vast distances between regions and diversity of populations, and acknowledges the rapidly changing landscape as we continue to learn from the emerging evidence.

Table 1: Suicide Prevention Action Plan 2025 approach – The Suicide Prevention Continuum





The WA Suicide Prevention Action Plan 2025



The Action Plan at a glance

Vision

A Western Australian community that experiences optimal mental health and wellbeing

Goal

To reduce the rate of suicide attempts and death by suicide in Western Australia

Purpose

To provide the framework for a coordinated approach to address suicide prevention activity in Western Australia from 2021 to 2025

Guiding principles

Everyone has a role in suicide prevention	Evidence-informed, integrated, cross-sectoral approaches are needed	Communities are empowered to lead local efforts which are tailored to local circumstances and priorities
Recognition that lived experience is essential to inform suicide prevention activity	Quality and timely interventions are available across the lifespan	Individuals, families and communities are supported to recover
Community wellbeing and resilience are fundamental	Earlier intervention to prevent and manage crisis	A sustainable service system, which takes into account the limited resources available
Care is culturally appropriate and compassionate	Support and care is matched to individual needs and preferences	

Enablers

Better use of data, information and evidence to support suicide prevention	Inclusiveness for all Western Australians, including those at increased risk	Partnerships, collaboration, and coordination of activities for better outcomes	Acknowledgment of the role that trauma and the social determinants of health have in suicide prevention
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Priority areas

Prevention	Intervention	Postvention	Aboriginal People
Community engagement and awareness to support positive change	Options for people experiencing suicidal crisis	Support for people and communities affected by a suicide death	Facilitate the development of a Western Australian Aboriginal and Torres Strait Islander Suicide Prevention Strategy with dedicated regional streams.
Mental health and wellbeing education, and suicide prevention training for communities	Competent and confident assistance for people who are suicidal	Streamlined notification processes	
Responsible reporting of suicide in the media	Restricting the means of suicide		
	Appropriate aftercare support following a suicide attempt		

Principles

Principles

These principles underpin the Western Australian Suicide Prevention Action Plan 2021-2025. They are drawn from the draft national suicide prevention implementation strategy for Australia's health system: 2020 -2023 and have been slightly modified to present a Western Australian perspective. In the development, commissioning, and implementation of suicide prevention activity it is crucial these principles are adhered to every step of the way.

Everyone has a role in suicide prevention

Having a role in suicide prevention activities is in every person's, community's and government's interest, because suicide impacts the entire community. It is far-reaching and long-lasting, with the potential to touch everyone directly and indirectly. Whilst the reasons for suicide are complex and multifaceted, many suicides are preventable. Everyone is encouraged to take a role in suicide prevention, no matter how great or small.

Recognition that lived experience is essential to inform suicide prevention activity

People with a lived experience of attempted suicide or who have been bereaved by suicide have great knowledge and expertise as do their families, carers and communities. The development and implementation of suicide prevention strategies must include their voices, and activities should be co-designed with people with a lived experience.

Community wellbeing and resilience are fundamental

Connection to community, a sense of belonging, equity and inclusion, willingness to engage in solutions and safe gathering places all contribute to community wellbeing and resilience. Fostering social connections, creating community safety and protecting against adversity will enable communities to adapt, recover and thrive through times of change and unpredictability.

Evidence-informed, integrated, cross-sectoral approaches are needed

It is preferable for activities to be produced and implemented on the basis of evidence about what does and does not work. When directly relevant evidence is unavailable, programs informed by evidence and best practice methods in similar fields can be implemented. The insights of people with lived experience of suicide; traditional forms of knowledge, such as from Aboriginal people and unique cultural perspectives, can form part of the evidence base for effective suicide prevention. Continual development, implementation and evaluation of existing and future initiatives is crucial.

However, it is also important that any evaluations of suicide prevention programs or activities are open to trialling new, innovative and non-traditional initiatives for prevention and early intervention.

Quality and timely interventions are available across the lifespan

Evidence shows us that early identification and effective management of individuals who are seeking help is key to reducing suicides. A variety of services need to be equipped to deliver evidence-informed and culturally secure interventions that prevent and respond to psychological distress and suicide-related experience for people of all ages.

Earlier intervention to prevent and manage crisis

Shifting the focus to earlier interventions, such as addressing risk and protective factors can have significant advantages for the whole population. At the individual level, early intervention is critical for those showing signs of suicidal crisis, as is a SEWB holistic approach for Aboriginal people.

Support and care is matched to individual needs and preferences

It is essential that individuals, their families and communities have a voice: care must be tailored to the person's circumstances, needs and underlying causes of distress. For some people this will involve mental health treatment or cultural healing. For others relationship counselling, employment or housing support could be what is needed most.

Care is culturally appropriate and compassionate

The diversity of individuals and communities needs to be valued and respected. Care which is kind and compassionate without prejudice, racism, stigma or judgement is essential. A compassionate approach requires an understanding of where the person came from, what they are connected to, how they got to where they are now and how they can move forward. People with lived experience report compassionate care is vital to their successful recovery.

Communities are empowered to lead local efforts which are tailored to local circumstances and priorities.

Suicide prevention approaches are more effective when they are community-driven and led, and reflect the social, emotional, cultural, socio-economic and spiritual needs of the community. WA is an expansive and diverse state, with each region having its own unique circumstances and challenges. Local people are best placed to determine what is required for their community. Their local knowledge, experiences and stories are essential for making a difference.

Individuals, families and communities are supported to recover

Compassion, understanding, and coordinated and practical support is required over the long-term to aid recovery from the impact of suicide.

A sustainable service system, which takes into account the limited resources available

Governments, service providers and communities must acknowledge resources fluctuate (sometimes dramatically) over time. Strategies for sustainability must be considered including the sharing of information, collaboration across services and working across governments.

Enablers

Suicide Prevention Action Plan 2025 activities can be implemented effectively only if the identified enablers are activated.

Better use of data, information and evidence to support suicide prevention

Improving the quality of evidence for suicide and suicide prevention activities is fundamental for the continuous improvement of community outcomes. Improved reporting of and learning from deaths by suicide needs to occur to help inform future suicide prevention activities. Promoting evidence-informed innovation, accompanied by thorough evaluation, will help build the evidence for new approaches.

Activities required to ensure enablers are activated include:

- Improved data collection, particularly at the community and population levels, relating to increased personal and community resilience to suicide.
- Collection of both qualitative and quantitative data including descriptive narratives from service providers.
- More academic research and practical information sharing between suicide prevention professionals and communities with lived experience.

Inclusiveness for all Western Australians, including those at risk

The Western Australian population is diverse and prevalence of suicide rates are skewed for certain groups. Certain groups in the community are disproportionately affected by suicide. Consideration of diverse cultures, languages, genders and sexualities is essential. Equally essential is the acknowledgment of situational stresses (such as relationship breakdowns, job loss, draught etc) that can affect individuals, families and communities at different times.

Activities required to ensure enablers are activated include:

- Empowering the voices of vulnerable populations, including Aboriginal, youth, migrants, refugees, LGBTI people, people who have attempted suicide, people who have been bereaved by suicide, people living in rural and remote areas, people in the justice system and first responders.

Partnerships, collaboration, and coordination of activities for better outcomes

Many of the factors that can influence suicide prevention occur in non-health settings. Close working relationships between governments at the local, state and national level, private and non-government sectors, research institutions and key community groups are essential. Funding models must promote collaboration.

Activities required to ensure enablers are activated include:

- The Mental Health Commission (MHC), with appropriate resource allocation will utilise Suicide Prevention Action Plan 2025, as a guiding document to facilitate and lead a coordinated whole-of-government response to suicide in Western Australia.
- Provision of appropriately qualified metropolitan and regionally based staff who engage with local service providers, community and stakeholders to coordinate and support regional (and local) suicide prevention initiatives.
- Definition of the roles and responsibilities of federal, state, local and non-government organisations in regards to suicide prevention, intervention and postvention in each region to address duplication and / or service gaps.

- Provision of opportunities for MHC-funded service providers to engage with each other regularly to support a more cohesive approach to strategy delivery and improve consumer pathways.
- Greater alignment with mandated Local Government Community Health Plans on practical initiatives.

Acknowledgment of the role that trauma and the social determinants of health have in suicide prevention

Suicide prevention is more effective when integrated with broad responses to the social and cultural determinants of poor health and wellbeing, including childhood trauma, family violence, poverty, displacement, experiences of discrimination, lack of education opportunities, isolation, loneliness and alcohol and other drug use.

- Collaboration across governments in equitable partnerships with local communities to address the social contexts and determinants that drive hopelessness in communities.
- Addressing homelessness, violence, child neglect, alcohol and other drug related-harms poverty etc.

We need to address the widespread pervasive hopelessness and social context rather than treating the symptomatic cycle of 'argument /suicide threat / police / ED / repeat'; The Office of the Chief Psychiatrist and the Mental Health Commissioner should recognise the Uluru Statement from the Heart to show that we recognise and support Aboriginal voices at the highest level. Suicide and hopelessness requires a system response to a system issue rather than treatment solely as an individual malaise.

Regional Service Provider (WA Suicide Prevention Action Plan 2021-2025 Engagement Report



Priority area activities



Prevention priority area activities

Prevention priorities are aimed at anyone who could benefit from learning, knowing, and doing more about mental health and wellbeing, and suicide prevention. They may have no experience of being suicidal or losing someone to suicide or they may have extensive personal experience. Strategies may target the whole-of-population, groups within it, and/or groups known to be at higher risk. Activities are aimed at preventing the onset of suicidal behaviour.

Community engagement and awareness to support positive change

Communities play a critical role in suicide prevention. They are able to access knowledge to identify and implement specific suicide prevention strategies relevant to their situation. This may include enhancing broad government strategies by localising them and/or coming up with specific activities unique to their community.

1.1 Empowering local people to determine and deliver those methods of suicide prevention that are most appropriate for their community through increased and more accessible grassroots suicide prevention resourcing.

1.2 Addressing the stigma of mental health and suicide in communities through community designed and led universal prevention and promotion initiatives at state, regional and community levels.

1.3 Expanding of public awareness campaigns to assist communities to connect with the best mental health and suicide (prevention) information, support, and services with the capacity to be localised as required.

1.4 Celebrating those with diverse cultures, languages, genders and sexualities within the community and at the service provision level.

1.5 Recognising and empowering youth voices in mental health or suicide prevention discussions and leadership through greater participation in decision-making, co-production of prevention initiatives and advice to services.

1.6 Providing dedicated peer-based mental health and wellbeing education and support for vulnerable populations with a key focus on Aboriginal people, LGBTI young people and men in rural and remote communities

1.7 Investigating community-based initiatives to reduce loneliness and increase social connections for high-risk populations.

Stigma

Stigma related to suicide remains a major obstacle to suicide prevention efforts. Those who are left behind or who have attempted suicide often face considerable stigma within their communities, which may prevent them from seeking help. Stigma can subsequently become a barrier to accessing suicide prevention services.



Case study - Think Mental Health

The Think Mental Health Program (TMH) has been built on the premise that strategies developed for mental health promotion will have a flow-on effect for suicide prevention. For example, building protective behaviours that promote mental health and wellbeing, or seeking early support when mental health is compromised, will translate into fewer incidents of suicidal behaviour.

TMH focuses on assisting people connect with the best information, support, and services for their particular situation. To achieve effective outcomes for mental health and suicide prevention, a broader focus has been taken to emulate the success achieved by other high-profile population based behaviour change campaigns, such as tobacco control.

A new TMH Men's Campaign (the campaign) was developed in response to consistently high suicide rates among men in Western Australia (WA). In 2017 over 70 per cent of suicide deaths in WA were men. The highest prevalence of suicide was among men aged 25 to 54 years who were consequently chosen as the primary target audience for the current phase of the TMH Men's Campaign. The secondary target audience is people who support men, such as partners, friends, family, or colleagues.

The main communication messages of the campaign were designed to motivate people who may be experiencing mental health issues, or family and friends of these people, to talk to each other when things aren't going so well and to connect them with mental health information, support and help appropriate to their situation and needs. This included:

- what to look out for when you or someone else isn't going so well;
- how to start the conversation and what to say;
- options on getting help and support; and
- what to do in a crisis situation.

Baseline research was conducted prior to the launch of the campaign to understand trends in community knowledge, beliefs, attitudes, intentions and behaviours in relation to mental health and wellbeing, mental health issues, help seeking, and barriers to help seeking (stigma). Research will be conducted to monitor and track attitudinal measures over time.

A post-campaign evaluation indicates that the messages taken out by males were on target, with the availability of help and encouragement of help-seeking registering strongly. As a result of seeing the campaign more than a quarter (28%) of all males had taken some form of action. When looking at the measures known to be important in campaign cut-through and effectiveness, the campaign performed extremely well amongst males on Novelty, Affective Impact, and Relevance - sitting within the top 25% of all Australian campaigns tracked to date.

At-risk men were those with a diagnosed mental health condition or who had experienced a significant life event in the previous two years. The campaign was particularly effective in reaching at-risk men with 70% recognising the campaign

when prompted. At-risk men were significantly more likely to talk about their mental health needs with a professional as well as with family/friends as a result of seeing the campaign.

Awareness of the campaign was also high amongst family and friends with 29% of family and friends spontaneously aware of the campaign and 69% demonstrating awareness when prompted. The campaign was also felt to strongly educate family and friends: 57% said it made them think about the mental health and wellbeing of males close to them; 49% were made aware of the TMH website; 48% were provided advice on how to approach someone they are concerned about; 38% were made aware of the support tools and tips available; and 37% were made aware of the symptoms of a mental health issue.

The next phase of the campaign will build upon these results to increase confidence in recognising signs and symptoms and supporting others in getting the right help to support their mental health and wellbeing.

Mental health and wellbeing education, and suicide prevention training for communities

Many people who are experiencing suicidal thoughts communicate distress through their words or actions but these warning signs may be missed or misinterpreted. Training can provide people with the knowledge and skills to identify warning signs that someone may be suicidal, talk to them about suicidal thoughts and connect them with professional care.

Activities required to ensure this priority is achieved include:

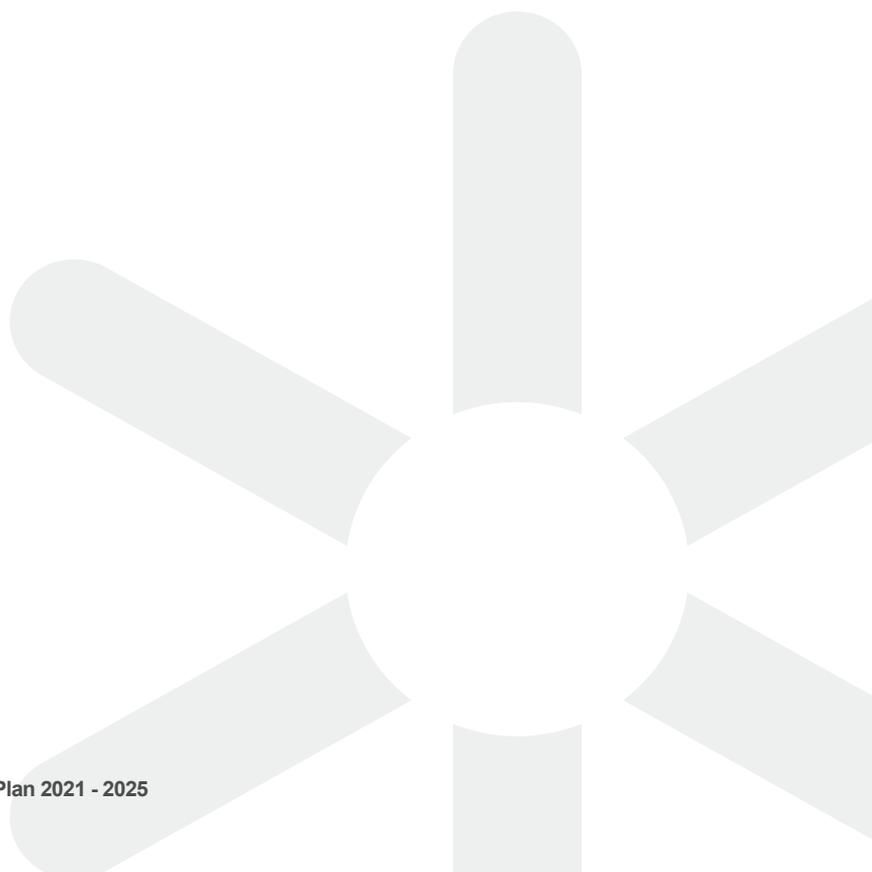
2.1 Expanding mental health and suicide prevention training and education to a wider cross section of the community through easily accessible and culturally appropriate formats.

2.2 Empowering peer support groups and networks that deal with mental health and suicidal ideation through appropriate recognition, supervision and resourcing.

2.3 Providing education and training that addresses the wider social context within which mental health and suicidal ideation develops, and focusing on building stronger protective behaviours in at-risk populations.

2.4 Providing mental health and wellness education, and suicide prevention training in schools.

2.5 Facilitating opportunities for reconnection to culture and country for Aboriginal people.



Responsible reporting of suicide in the media

Suicidal behaviour can be influenced through the media. Media guidelines supporting the responsible reporting of suicide can reduce suicide rates, and improve awareness and help-seeking .

Activities required to ensure this priority is achieved:

3.1 Working with journalists to increase their competency with respect to the MindFrame reporting guidelines.

3.2 Educating communities, particularly school age youth and parents, about identifying distress and cries for help on social media and the application of Mental Health First Aid-style principles in online environments.

Community suggestions

- Co-designing and co-producing national and state based prevention messages such as RUOK? and Think Mental Health with community members to reflect a more localised approach.
- Encouraging community members to actively check-in on, and listen to, family and community members everyday.
- Holding public events to showcase cultural, language, gender and sexuality awareness.
- Providing greater social outreach opportunities through existing youth services.

Empowering local people to determine those methods of suicide prevention that are most apt for their community will ensure local buy in, innovation, social inclusion and a sense of belonging. Every community appears to have the 'right' answer for addressing suicide in their context and all display great levels of insight and innovation in methods. These methods often manifest in community and social engagement activities and whilst these initiatives may not always be evidence based, they are critical to providing local ownership, hope and the necessary community dialogue to support more evidence based, prevention.

Engagement summary 2019

Intervention Priority Area

Intervention priorities are aimed at individuals who are showing early signs of suicidal behaviour, experiencing suicidal crisis. This includes those who have recently been suicidal, and the people who support them. These strategies focus on decreasing suicidality and reducing the likelihood of suicidal behaviour resulting in death.

Options for people experiencing suicidal crisis

Suicidal behaviour is complex and there are many reasons why someone may be having suicidal thoughts. Early intervention and providing people with a range of support and/or treatment options can reduce the risk of someone taking their life.

Activities required to ensure this priority is achieved include:

4.1 Providing increased and equitable access to mental health and SEWB services for people in mental distress and/or with suicidal ideation.

4.2 Facilitating access to culturally appropriate healing-centred practices and recovery options for migrant and refugee populations.

4.3 Addressing the critical lack of after-hours support for people in suicidal crisis outside of emergency departments (EDs) and anonymous helplines, especially in rural and remote settings.

4.4 Providing alternatives to EDs for those in mental distress and/or suicidal crisis.

4.5 Reducing the stigma and fear of calling the police for people experiencing acute mental distress and suicidal behaviour.

4.6 Redesigning existing EDs settings to more compassionately cater for those in mental distress.

4.7 Increasing access to appropriate mental health and support services for the specific needs of targeted vulnerable populations and including those relating to family and domestic violence, homelessness, alcohol and other drug use and/or trauma.

4.8 Expanding access within schools and specific services for children and young people in mental distress and suicidal crisis across the WA.

Community Suggestions

- Accessing options for those people who prefer to avoid local services due to lack of anonymity in small towns;
- Crisis helplines with the ability to retain personal information on previous callers that can be accessed upon request/permission to avoid having to retell personal stories;
- Opportunities for face-to-face connection in non-clinical safe haven café settings for open, normal discussions without the need to feel shame;
- Expansion of the Police Mental Health Co-Response model;
- In emergency departments provide safe, quiet, low light environments in separate rooms that lessen distress and can also account for cultural, language, gender or sexuality security;
- Increase resourcing for Aboriginal social and emotional wellbeing workers and Aboriginal liaison officers across the State; and
- Provide non-clinical youth worker style support and interventions.

Suicide and self-harm are not black and white but the responses always are - ED or not, medication or not. You can still have those thoughts every day and self-harm but not want to act on them. You need complex help, and medication or ED shouldn't be the first and only option.

Regional LGBTI Teenager



Case study - Mental Health Co-Response Program

The Mental Health Co-Response Program (MH-CR) was implemented in January 2016 in response to increased demand on Police to attend and manage incidents that involved a mental health element.

This increase in demand coincided with national concerns about the ability of police officers to respond appropriately to mental health incidents. The MH-CR is a joint initiative between the WA Police Force, the WA MHC and Health Service Providers (HSPs), and enables police and mental health clinicians to share information and jointly attend crisis situations where mental illness is identified as a likely factor.

The MH-CR model provides a distinct multiagency service responding to particular mental health-related circumstances, including calls for assistance where a mental health or welfare concern has been indicated; requests for advice, guidance or assistance

from frontline police officers who suspect a member of the community is experiencing a mental health episode; and the admission of arrested people with mental health issues or a history of mental health intervention to the Perth Watch House who require assessment, monitoring and diversion pathways.

The MH-CR trial, which incorporated mental health expertise at each stage of police involvement – from the point of dispatch, to the point of physical contact at the scene, and following arrest within the custody setting, was the first of its kind in Australia. There are four components which support the delivery of the MH-CR model:

1. Police Operations Centre where a Mental Health Practitioner is located to obtain and share relevant information from health databases.
2. MH-CR Mobile Teams which include an Authorised Mental Health Practitioner and uniformed Police Officers in an unmarked vehicle to respond to incidents involving a mental health crisis.
3. Perth Watch House where an Authorised Mental Health Practitioner is on duty

to observe and screen detainees as they are processed and provide further assessment if needed.

4. MH-CR Unit which co-locates WA Police and Department of Health personnel and provides managerial oversight.

Over the course of the two-year trial the following results were achieved:

Police Operations Centre
20,149 tasks reviewed by the mental health practitioner including welfare checks, missing persons and mental health incidents.

Mobile Teams
2,907 mental health consumers were engaged/assessed by Co-Response teams (1,318 by the South East Metropolitan District mobile team and 1,589 by the North West Metropolitan District mobile team).

There were 328 and 389 referrals to mental health and other community services by the South East Metropolitan District mobile team and the North West Metropolitan District mobile team respectively.

Perth Watch House
8,671 detainees screen by the mental health practitioner.

A total of 705 referrals were made from the Perth Watch House (139 to mental health court liaison services, 383 to external mental health services and 183 to other community services).

An independent evaluation of the trial showed benefits to resource allocation, the safety and wellbeing of officers and mental health consumers, and interagency collaboration at each stage of the model. Findings also indicated that although Police are being called to a growing number of mental health incidents, the majority are not criminal incidents. Interviews revealed that mental health consumers and their carers engaged positively with the MH-CR model and saw it as a significant improvement over the traditional crisis response used by police. The MH-CR has strengthened the partnership between the WA Police Force and mental health services, leading to improved overall mental health and wellbeing outcomes for consumers. In response to the success of the trial, the MH-CR has since been expanded to cover the whole Perth metropolitan area.

Competent and confident assistance for people who are suicidal

Those who support people in suicidal crisis need to have the knowledge and skills to provide care that will make the person seeking help feel safe and reduce their risk.

Activities required to ensure this priority is achieved include:

5.1 Expanding Mental Health First Aid, ASIST, Gatekeeper and other culturally appropriate training to all health, mental health and primary care staff.

5.2 Embedding culturally secure, trauma informed and compassionate procedures and responses into EDs as well as crisis and support services.

5.3 Implementing consistent assessment and early intervention frameworks and services for suicidal ideation and behaviour.

5.4 Recognising and supporting peer support and response models for people in acute mental distress and suicide crisis

5.5 Acknowledging the high burnout rates of staff, in particular those in community prevention, isolated rural and remote counselling roles and outreach and volunteer workers.

5.6 Providing local services with access to more timely and accurate regional self-harm, suicide attempt and death by suicide data regionally

Community suggestions

- Increase trauma-informed training and practices embedded in WA Police and ED settings, and other human services such as Centrelink and Department of Housing;
- Providing for early intervention within schools through school psychologists and chaplains;
- Up-skill family members and volunteers within communities with strong yarning and distress management skills (and pay them as local suicide prevention liaison officers);
- Provide free and easily accessible counselling for community members, volunteers and families who are 'holding it together' for people in crisis within their communities.

Restricting access to the means of suicide

Reducing access to the means of suicide is one of the most effective suicide prevention strategies. Making it more difficult for a person to access means, or by interrupting a person's immediate means for taking their life, allows time for the suicidal crisis to pass. This, coupled with encouraging help-seeking and the intervention of a third party significantly reduces the potential for suicide.

Activities required to ensure this priority is achieved include:

6.1 Coordinating a multi-agency collaboration across government to identify and establish barriers or mechanisms that can interrupt the suicidal process.

6.2 Manage alcohol and other drug-related harm in the community.

6.3 Establishing cross-functional working groups on suicide means restriction as part of suicide prevention planning.

Appropriate aftercare support following a suicide attempt

Aftercare refers to the care, treatment, help or supervision received by people after a suicide attempt, and extends to family and carers. Evidence tells us that a suicide attempt is the strongest risk factor for a subsequent suicide, and the period of highest risk is following release from hospital or medical treatment. Appropriate aftercare is essential in suicide prevention.

Activities required to ensure this priority is achieved include:

7.1 Address major breakdowns in after care following a suicide attempt through increased safety planning and referral pathways post discharge from hospital or medical treatment.

7.2 Empowering, equipping and supporting families and carers to successfully navigate mental health and suicide prevention networks and systems.

7.3 Providing families and carers with accessible and formal peer support, community based support and education, and respite opportunities in the ongoing recovery phase

Community suggestions

- Regular follow up counselling of high-risk individuals (beyond the 10 sessions a year covered by Medicare rebates);
- Create continuity of care with the same professional staff to build up a rapport rather than having to re-explain details to new staff at each visit;
- Offer in-home support services and home visitation; and
- Resource volunteer and peer support services during times of need to provide emotional and practical support.

Postvention Priority Area

Postvention refers to intervention after a death by suicide, to support affected individuals and communities. It aims to assist people who are bereaved (family, friends, professionals and peers) to recover from trauma, major stressors, and cope with grief and loss.

Postvention priorities target people and communities who have been affected by the death of someone from suicide. These strategies meet bereavement-related needs that may occur over a lifetime and focus on providing support and limiting the ongoing harmful consequences of a suicide death for others.

Support for people and communities affected by a suicide death

Bereavement due to suicide can be complicated. The often sudden and sometimes unexpected nature of the death can be extremely traumatic and in addition to grief the bereaved can experience shock, isolation, questioning 'why' anger, rejection and guilt. Bereavement by suicide is a specific risk factor for suicide attempt among young adults whether they are related to the deceased or not and it is important that people and communities are supported appropriately to prevent further harm.

Activities required to ensure this priority is achieved include:

8.1 Establishing clear scope of service and protocols for suicide postvention coordination between existing federal, state and community based services and roles.

8.2 Providing ongoing practical and financial support to families directly affected by a suicide in locally and culturally relevant ways.

8.3 Increasing access to dedicated and ongoing postvention and bereavement services for families, communities, children and young people bereaved by suicide.

8.4 Educating service providers on suicide postvention evidence, best practice models and available pathways to support.

In the immediate aftermath of a suicide, the bereaved need immediate practical and financial support in order to be allowed the time to grieve. This includes meals, extended leave from workplaces and assistance preparing memorials. Person-centred care is required as there is no universal answer to postvention support.

Engagement summary 2019 (WA Suicide Prevention Action Plan 2021-2025 Engagement Report)

Build community capacity to respond to the needs of those affected by a suicide death

The painful experience of grief and bereavement following suicide loss is further complicated by the effects of stigma and trauma. Increasing the skills and knowledge of communities to be able to respond safely, appropriately and in a manner that does not inadvertently cause harm is essential.

Activities required to ensure this priority is achieved include:

9.1 Facilitating the development of community-designed and agreed crisis/postvention plans and protocols for high-risk populations.

9.2 Providing dedicated opportunities and resourcing for ongoing community and peer level healing.

Streamlined notification processes

Real-time and better integrated data at the community level will help provide responsive suicide prevention services and supports. Systems across government will assist with suicide prevention policies and the transfer of research findings into practice.

Activities required to ensure this priority is achieved include:

10.1 Improving the timely and accurate reporting of suicide deaths in Western Australia

10.2 Establishing more consistent and timely reporting of WA Police and hospital data on self-harm, suicidal ideation and suicide attempts to public mental health, Aboriginal Community Controlled Health Organisations (ACCHOs) and non-government services in the community.

Community suggestions

- Develop clear and agreed postvention network support pathways (at the local level) for families and affected communities.
- Provide meals and 'sorry time' specific foods, bedding and power-cards for visiting family and friends.
- Provide transport for family support, and funeral arrangements;.
- Educate services on how to support people bereaved by suicide and the language to use.
- Support community-based services such as community groups and events, yarning groups and memorial activities.

As well as increasing public awareness of the impact of suicidal behaviour we must look to educate and empower individuals and communities in how to get help, give help and save lives.

The Ripple Effect: Understanding the exposure and impact of suicide in Australia



Case study - Metropolitan Suicide Prevention Coordinator (SPC) Postvention Project

In 2018, members of the Metropolitan SPC Postvention Development Group (over 30 key government, community and lived experience representatives) agreed to develop and trial a community postvention model in Perth.

The proposed community postvention model would be informed by international and Australian evidence and be flexible enough to be adapted to 'best-fit' by the broad range of potential stakeholders in the metropolitan area.

The first group which identified an interest in trialling such an approach was Bowra & O'Dea Funeral Directors. Their 112 staff perform over 3 500 funerals in the metropolitan area per annum. In Australia, funeral service staff are the most prevalent service used following a bereavement. While they are on the frontline with families and friends following a suicide there has been little acknowledgement of the role of funeral service staff or their potential for playing an important part in community postvention.

In an Australian first, the Metropolitan SPC team has been working with Bowra & O'Dea to co-design and pilot a community postvention model which will equip staff to work appropriately with suicide bereavement funerals, including:

- a training package covering: the use of appropriate language; de-mystifying stigma and myths around suicide; understanding complex grief; and self-care for staff;
- a range of client and staff resources providing information about the experience of suicide bereavement, referral and support services;
- a range of organisational interventions around workflow and communication to further support good practice around suicide bereavement funerals.

The process of testing and reviewing the effectiveness of this community postvention model will continue to the end of 2020 and is being formally evaluated by UWA and a group of experts with experience of working with people bereaved by suicide. The findings will consider the potential application of this model to broader community contexts.

Aboriginal People Priority Area

For Aboriginal people and their communities, SEWB is the foundation for a holistic concept of physical and mental health. This concept is strongly influenced by a connection between Aboriginal people and family, culture, country, community, spirituality and Elders. These connections work together to provide a culturally safe and appropriate environment for Aboriginal people, and help individuals to enhance their SEWB.

The wellbeing of Aboriginal people is influenced by physical health, mental health, education, employment, economic engagement and cultural wellbeing. Addressing the impacts of trauma, grief, loss, discrimination and human rights issues experienced by Aboriginal people are also critical elements.

While the experience of SEWB varies between different Aboriginal people, groups and locations, there are common elements which help to enhance SEWB. These include:

- A holistic approach which extends further than mental health, and focusses on the broader context and life pathways of individuals and families;

- A strong link between collective and individual wellbeing;
- Recognition and promotion of the importance of family support; prioritising the need to work with the whole family and not just the individual;
- An understanding and acknowledgement of connection to land and community;
- Acceptance and understanding of the legacy of history and contemporary impacts on health and wellbeing;
- Flexible delivery of services including outreach, home support, on country and in schools;
- Promotion of an 'open door policy' where there is no judgement or exclusion;
- Understanding the importance of language, cultural healers, and traditional medicines that are trusted by the community.

The following recommended activities aim to support the healing and restoration to wellbeing and mental health both individually and collectively for Aboriginal people (Gayaa Dhuwi Declaration).

11.1 Facilitate the development of a Western Australian Aboriginal and Torres Strait Islander Suicide Prevention Strategy with dedicated regional streams.

11.2 Facilitate access to culturally appropriate healing-centred practices and opportunities for reconnection to culture and country for Aboriginal people.

11.3 Develop and deliver a culturally appropriate public awareness-raising campaign aimed to support Aboriginal people.

11.4 Recognise and empower Aboriginal youth voices in mental health or suicide prevention discussions and leadership through greater participation in decision making, co-production of prevention initiatives and advice to services.

11.5 Provide increased and equitable access to SEWB services for Aboriginal people in mental distress and/or with suicidal ideation, including the engagement of Elders and Traditional Healers where required.

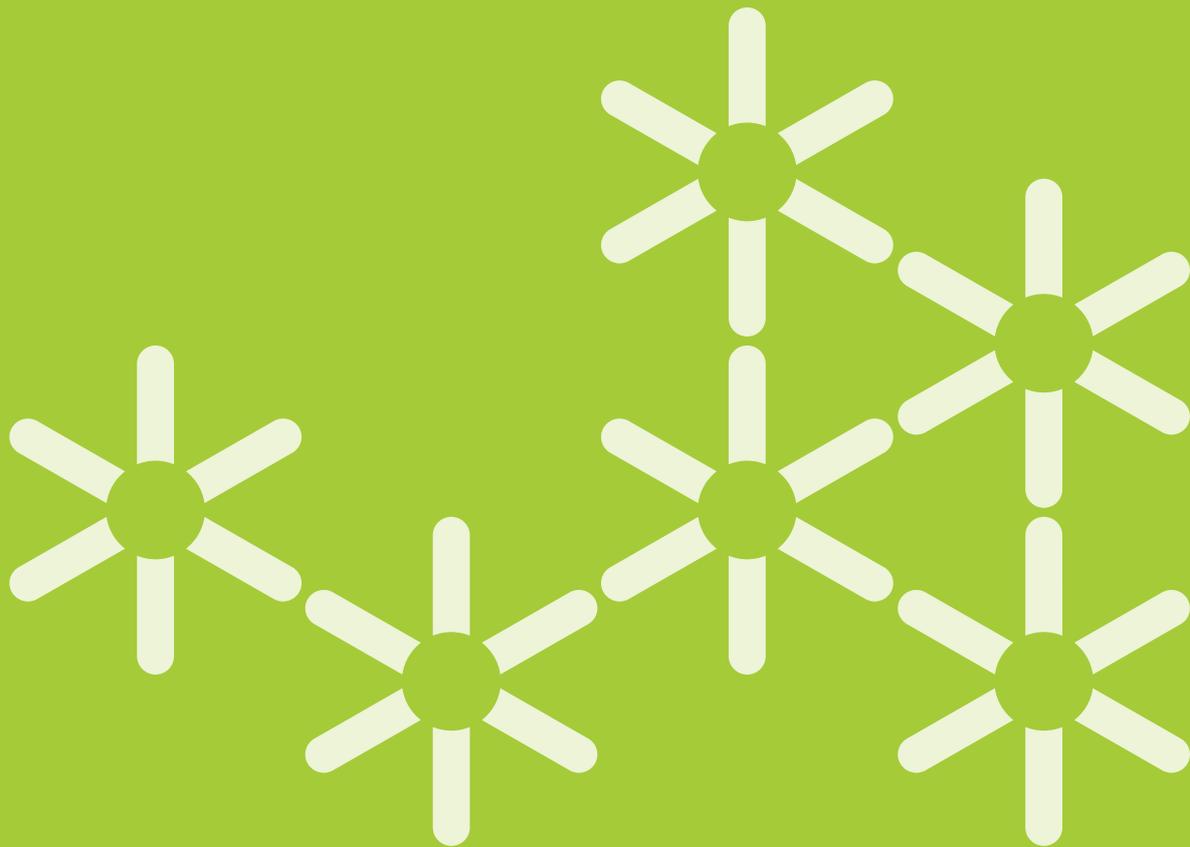
11.6 Empower ACCHOs and Organisations and other community organisations to provide culturally appropriate suicide intervention services for Aboriginal people.

11.7 Embed culturally secure, trauma informed and compassionate procedures and responses into crisis and support services.

11.8 Provide ongoing practical and financial support to families directly affected by a suicide in locally and culturally relevant ways.



How we developed the plan



How we developed the plan

A program logic model Framework (The Suicide Prevention Framework for Western Australia 2021 – 2025, appendix 1) guided the development of the WA Suicide Prevention Action Plan 2025

Plan consultation

Who we engaged

- 554 individuals in 110 separate face-to-face engagements (yarns, focus groups, workshops),
- 431 individuals via an online survey
- Revision and analysis of 19 previous consultation reports and papers published between January 2015 and June 2019 that related to Suicide Prevention activity.
- Steering committee: representatives from key agencies and community groups provided advice and guidance and helped to represent the voices of vulnerable populations, sector and academic experts.
- Government Advisory Group: a mix of representatives from federal and state government.

What we heard

- Social determinants need to be addressed – housing, education, employment and health care...
- Culture and country are important.
- We need to empower local communities for community-led suicide prevention activities
- Suicide prevention education should be expanded to a wide cross section of the community
- There is a need for a greater range of options for people experiencing suicidal crisis
- Pro-active follow up aftercare following a suicide attempt is needed

Emerging evidence and literature

New Frameworks and literature

- Alliance Against Depression (AAD) model Black Dog LifeSpan Integrated Suicide Prevention (LifeSpan) model
- Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project (ATSISPEP)
- Review of 15 strategic government documents that have direct or indirect involvement in addressing suicide within WA (Appendix 2)

From the literature we learnt

- A systems-based approach is essential: this means multiple strategies, delivered simultaneously that focus on individuals, high-risk groups and the whole population
- Social determinants of health need to be addressed
- An Aboriginal-specific Suicide Prevention Plan must be developed
- Cross-government collaboration is required

Evaluation of Suicide Prevention 2020

How we evaluated

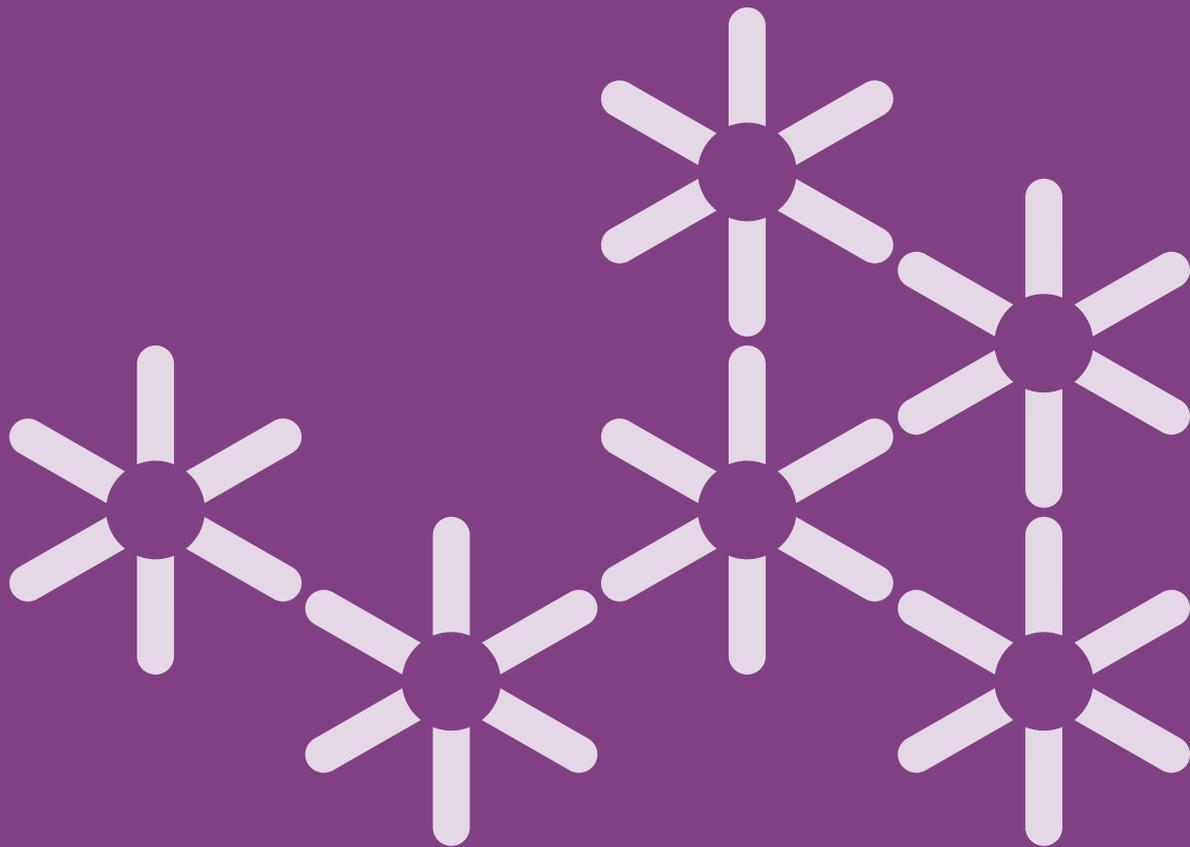
- Internal ongoing evaluation and monitoring of Suicide Prevention 2020.
- Independent evaluation of Suicide Prevention 2020.

Key Findings from the evaluation

- We need better coordination at the local level and of community-led activities
- Aftercare (following a suicide attempt) should be addressed as a separate issue to postvention (following a suicide death).
- Longer-term funding agreements for service providers are needed
- Collection of quantitative and qualitative community-level data is important
- Suicide prevention activity needs to be coordinated across government, non-government organisations and community groups



Everyone has a role in Suicide Prevention



Everyone has a role in Suicide Prevention

The MHC acknowledges the vision of the Suicide Prevention Action Plan 2021-2025 cannot be achieved in isolation. Identifying the roles of government, organisations and community efforts is important.

Many services and agencies which do not have suicide prevention as part of their core business may not recognise they may be engaged with some of the most vulnerable members of the community. They have an important role in identifying and responding to those who may be vulnerable to suicidal behaviour due to risk factors such as financial hardship, relationship loss, trauma, legal issues, and social isolation.

Every life highlights the need for suicide prevention activities to be embedded into the core business of all agencies.

Commonwealth Government

The Commonwealth Government is responsible for the development and implementation of national frameworks including the delivery of funds, programs and services. For example the Primary Health Alliance develops regional suicide prevention plans in partnership with hospital and health services and other key sectors.

Western Australian Government

The WA Government is responsible for the development of state-wide strategies and plans and includes the delivery and funding of programs and services that improve wellbeing at the community, organisational and individual levels. These include housing, employment, health, disability and financial support, transport assistance, workplace supports, the justice system and education programs.

Local Government

Local governments are responsible for developing the local community in a socially just and environmentally responsible way. This can include local infrastructure, parks and recreation facilities, health services, building and planning licensing and the provision of cultural facilities and events.

Non-government organisations, and the private sector

The non-government and private sector delivers a range of face-to-face and online services and plays a large role in supporting individuals and the community in advocating for change. This sectors includes peak bodies such as the Aboriginal Health Council of WA, The WA Association for Mental Health and

the Youth Advocacy Council of WA. Non-government and private sector organisations are also responsible for providing employment and workplaces that are safe and healthy.

Individuals and communities

Individuals, families and groups that make up our community share the responsibility of providing safe and secure environments and building supportive positive relationships between friends, families, neighbourhoods and community groups.

Suicide is often caused by situational, not mental, causes and this needs to be recognised and addressed in a holistic, not siloed, approach. In fact, in some regions and communities, addressing the social determinants that drive hopelessness and have a marked impact on an individual's social context, mental health and suicidality is seen as the most pressing activity for suicide prevention in the near and long term. These social determinants include, but are not limited to, domestic and family violence, alcohol and drug use, homelessness and overcrowding, and unemployment, poverty and hunger and require a whole of government response.

*Engagement summary 2019
(WA Suicide Prevention Action Plan 2021-2025 Engagement Report)*

Building blocks for a cross government approach

To reduce the potential for duplication of services and to further understand the interaction between government departments in relation to suicide prevention activity, the MHC commissioned a desktop review of 15 key government documents.

Suggestions, recommendations, strategies, priorities and actions from within these documents were cross-referenced against the Priority Areas of the draft Suicide Prevention Action Plan 2025:

- Suicide Prevention
- Suicide Intervention
- Suicide Postvention

- Aboriginal-specific
- Social Determinants
- Other (Governance Issues and Research).

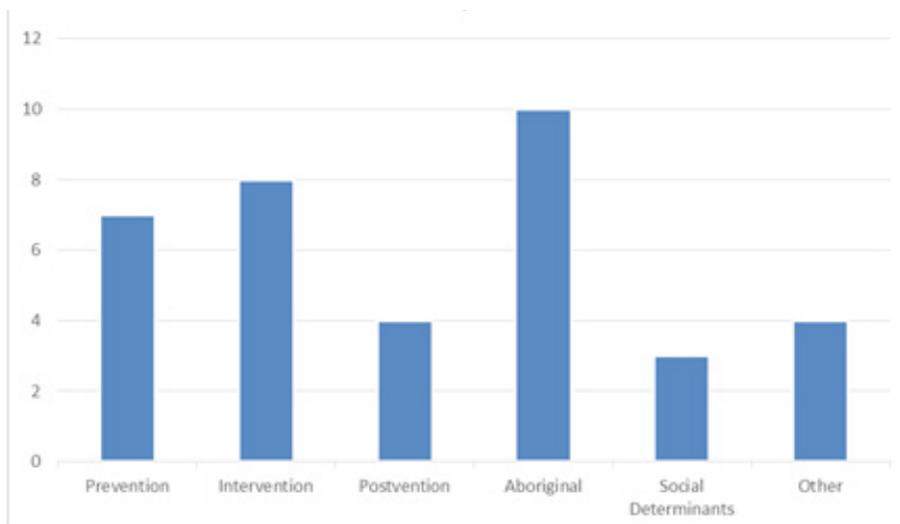
Figure 2 identifies the Priority Areas listed within the Suicide Prevention Action Plan 2025 and their relationship to the key documents.

The desktop review identified suicide prevention, suicide intervention and Aboriginal-specific as the priority areas covered in the highest numbers of documents. The areas of postvention and social determinants of health were covered in the fewest documents. Aboriginal suicide prevention and intervention experts strongly recommended culturally secure strategies that recognise and utilise the knowledge within

Aboriginal communities, with many recommending collaborative works or Aboriginal-led initiatives. Several authors discussed the need for Government leadership in collaborative approaches.

The MHC, with appropriate resource allocation will utilise the Suicide Prevention Action Plan 2025, as a guiding document to facilitate and lead a coordinated whole-of-government response to suicide in Western Australian.

Figure 2: Number of papers that include elements of each major priority area



What works well

Evidence-based models

To address suicide effectively accumulating evidence supports implementing multiple strategies, delivered simultaneously across a range of areas. This spans from individual-level to public health interventions in localised regions. This is referred to as a systems-based approach. The World Health Organisation have identified the following 11 elements as priority areas to focus on when addressing suicide^{vi}:

Surveillance

Increase the quality and timeliness of data on suicide and suicide attempts;

Means restriction

Reduce the availability, accessibility and attractiveness of the means to suicide;

Media

Promote implementation of media guidelines to support responsible

reporting of suicide in print, broadcasting and social media;

Access to services

Promote increased access to comprehensive services for those vulnerable to suicidal behaviours and remove barriers to care;

Training and education

Maintain comprehensive training programs for identified gatekeepers;

Treatment

Improve the quality of clinical care and evidence-based clinical intervention, especially for individuals who present to hospital following a suicide attempt;

Crisis intervention

Ensure that communities have the capacity to respond to crises with appropriate interventions;

Postvention

Improve responses to, and care for, those affected by suicide and suicide attempts;

Awareness

Establish public information campaigns to support the understanding that suicides are preventable;

Stigma reduction

Promote the use of health services;

Oversight and coordination

Utilise institutes or agencies to promote and coordinate research, training and service delivery in response to suicidal behaviours.

In Australia, the LifeSpan Model (appendix 2) developed by the Black Dog Institute is an evidence-based, integrated approach that combines nine strategies that have strong evidence for suicide prevention into one community-led approach. The AAD (formally the European Alliance Against Depression, (appendix 3) is another systems-based model focusing on improving care for people living with depression and preventing suicidal behaviour.

Factors that influence suicidal behaviour

Not all people who attempt or die by suicide have lived experience of mental health issues. Many factors influence a person to attempt to take their life. Most commonly, several risk factors accumulate over time which can increase an individual's vulnerability to suicide. These risk factors can occur at the individual, community or structural level and often interact.

For Aboriginal people, health and wellbeing is directly related to holistic determinants of health; any disturbance to these determinants can increase risk of experiencing suicidal behaviour. These determinates include; connection to community, family, land, culture and

country, and physical, emotional and spiritual wellbeing.

Although not exhaustive, table 1 provides a list of known risk factors for suicidal behaviour grouped into categories demonstrating the multiple levels at which risk factors can operate. It also helps to reinforce the role that everyone has in suicide prevention.

Some populations and groups are more vulnerable to suicide and suicidal behaviour. These include: Aboriginal people; persons who have experienced abuse, trauma, conflict or disaster; refugees and migrants; prisoners and others in contact with the justice system; lesbian, gay, bisexual, transgender and intersex persons (LGBTI); frontline workers, individuals who have had a previous attempt and people suicide bereaved.

At the other end of the spectrum protective factors can help reduce a person's vulnerability to suicidal behaviours and increase their capacity to cope with particularly difficult circumstances. Key protective factors identified by the WHO are:

- Strong personal relationships, including connections to family, culture and community
- Lifestyle practices that includes positive coping strategies and general well-being.

Upstream approaches

Use of "upstream approaches" such as addressing risk and protective factors early in the life course has the potential to "shift the odds in favour of more adaptive outcomes" over time. Additionally upstream approaches may simultaneously impact a wide range of health and societal outcomes such as suicide, substance abuse, violence and crime.

Table 1: Risk factors (adapted from WHO, 2014vi)

Health systems	Society	Community	Relationships	Individual
Barriers to accessing health care	Access to means Inappropriate media reporting Stigma associated with help seeking behaviour	Disaster, war and conflict Stresses of acculturation and dislocation Discrimination Trauma or abuse	Sense of isolation and lack of social support Relationship conflict, discord or loss	Previous suicide attempt Mental disorders Harmful use of alcohol and other drugs Job or financial loss Hopelessness Chronic pain Family history of suicide Genetics and biological factors

The National suicide prevention strategy for Australia's health system: 2020 – 2023 prioritises research designed to increase “understanding of protective factors for suicide, including why they are protective, for whom and what universal interventions bolster these protective factors and address ‘upstream’ issues”.

It is important to acknowledge that the presence of risk factors does not necessarily mean a person will take their life. Similarly, a person may experience suicidal behaviour even if there are multiple protective factors in their life. It is also important to understand that risk and protective factors are not simply opposites of each other.

The literature continues to reference the social determinants of health as a factor in suicidal behaviour. The social determinants of health, sit outside the health system but have the potential to significantly affect the health of populations.

Social Determinants of Health

Our health is largely determined by factors outside the health system, including our environment, the choices we make and broader social factors. Social determinants of health can be defined as, ‘the circumstances in which people grow, live, work, and age. The social determinants of health are mostly responsible for health inequities’.

Social determinants of health include socio-economic position, foundations built in early life, social exclusion, social capital, employment and work, housing and residential environment. The physical environment also influences our health. ‘Safe water and clean air, healthy workplaces, safe houses, communities and roads all contribute to good health. Employment and working conditions – people in employment are healthier, particularly those who have more control over their working conditions’.

To reinforce across WA as part of this and other engagement processes, communities identify social determinants as one of the most important factors that needs to be addressed to prevent suicides and suicidal behaviour. Whilst the MHC can influence some of the direct factors influencing suicidal behaviour, there needs to be a commitment across government to acknowledge and address issues that affect the

social determinants of health.

Aboriginal people and their communities play an important role in identifying their health needs and shaping innovative local responses to strengthen their SEWB and Mental Health. Central to Aboriginal health and well-being are cultural connections to family, community, culture, language and culture, and spiritual, physical and emotional wellbeing.

Disconnection from these elements can cause an individual to experience an imbalance in their overall health and wellbeing, not only from a medical point of view but from an Aboriginal and cultural perspective. This holistic approach to health recognises that for Aboriginal people and their communities’ good health is more than just the absence of disease or illness.



Figure 2: Copyright Gee, Dungeon, Schultz, Hart and Kell, 2013

Social and Emotional Wellbeing

Aboriginal peoples health itself is not understood as the concept often assumed by non-Aboriginal people, rather it is a culturally informed concept, conceived of as 'social and emotional wellbeing' – a term that is increasingly used in health policy but in this context carries a culturally distinct meaning: it connects the health of an Aboriginal individual to the health of their family, kin, community, and their connection to country, culture, spirituality and ancestry. It is a deep-rooted, more collective and holistic concept of health than that used in Western medicine.

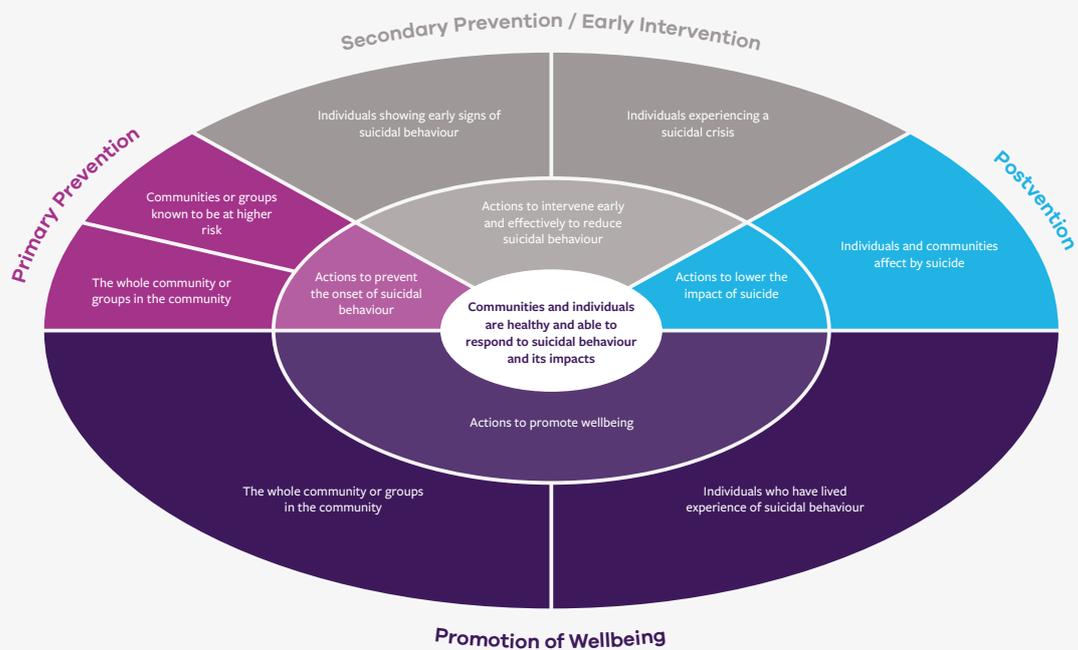


Figure 4:Prevention First Framework (adapted for suicide prevention)

Everymind Prevention First

The Everymind Prevention First Framework adapted for suicide prevention (see Appendix 5 for further explanation) further provides a helpful overview for understanding the approach of the Suicide Prevention Action Plan 2025 as it relates to the priority areas of prevention, intervention and postvention.

Suicide prevention interventions can be categorised as follows:

Universal

Interventions targeting the whole population, designed to maximise health and minimise suicide risk.

Selective

Interventions targeting vulnerable groups within a population based on characteristics such as age, gender,

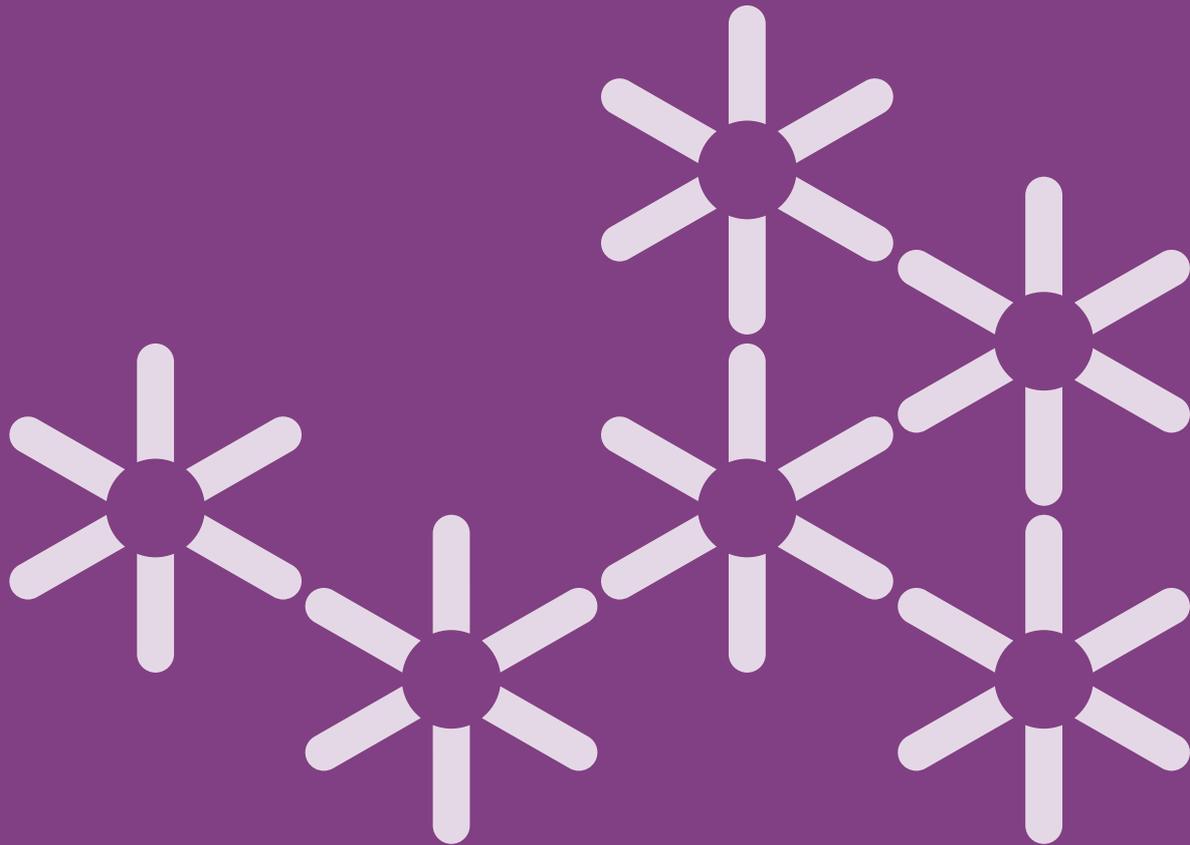
occupation, family history or cultural heritage. While individuals may not currently express suicidal behaviours they may be at an increased risk.

Indicated

Interventions targeting specific vulnerable individuals within the population such as those showing early signs/behaviours linked to suicide potential or who have made a suicide attempt.



Monitoring, Evaluation and Reporting



Evaluation strategies

Ongoing monitoring and evaluation will be central to the successful development and implementation of the Suicide Prevention Action Plan 2025. It is important the activities delivered as part of the Plan are informed by evidence, promote safe practice, and are likely to achieve their intended outcomes.

Monitoring and evaluating the Suicide Prevention Action Plan 2025 will allow the MHC to track what is happening and support the continuous improvement of the individual programs and services that are funded, as well as the overall action plan.

The Suicide Prevention Action Plan 2025 has been developed with a program logic approach incorporated into the framework. Each of the priority areas has several associated short and intermediate term outcomes to be achieved through implementing the activities. Evaluating activities is crucial to determining if what is being implemented is making a difference.

Data to provide the evidence that these outcomes have been achieved, or that progress towards their achievement has been made, will be collected by the programs and services funded under the Suicide Prevention Action Plan 2025.

Short and intermediate-term outcomes

How will we know the activities are making a difference

Program and/or service outcomes for the WA Government, service providers and communities to consider when implementing activities are listed below.

Prevention

- Increased literacy surrounding mental health and wellbeing and suicide prevention
- Decreased stigma associated with mental health issues and suicide
- Increased ability to seek help for oneself or for someone else
- Increased coping skills and ability to manage difficult life experiences

Intervention

- Improved care and support for individuals in crisis
- Improved care and support for those assisting individuals in crisis
- Improved functioning following crisis
- Decreased symptoms following crisis
- Decreased access to means for those in crisis
- Improved response to suicidal behaviours
- Increased quality of data on suicidal behaviours
Increased timeliness of data on suicidal behaviours

Postvention

- Improved care and support for those affected by a suicide
- Increased quality of data on suicide,
- Increased timeliness of data on suicide

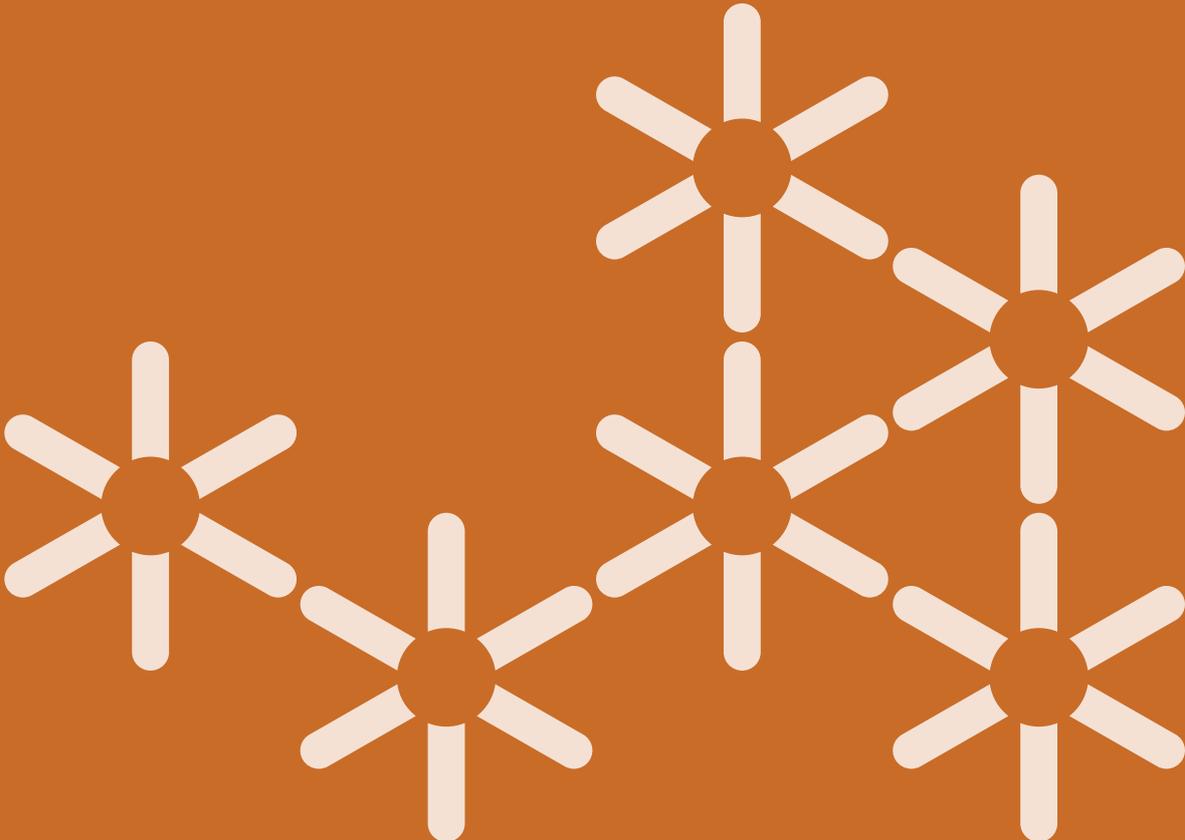
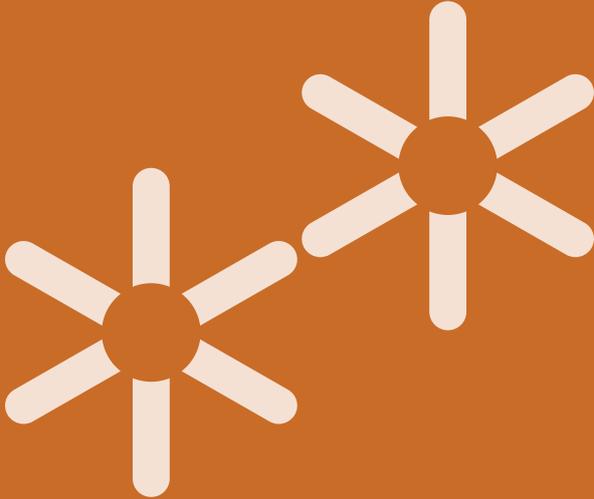
As longer-term community and state-wide population outcomes are influenced by other factors, they cannot be the sole responsibility of the funded programs and services. However, as the short and intermediate-term outcomes feed in to the long term outcomes, progress towards these outcomes will be monitored as part of the delivery of the Suicide Prevention Action Plan 2025.

Formative and summative evaluations

Short and intermediate-term outcomes will be monitored annually, with formative and summative evaluations conducted periodically during the delivery of the Suicide Prevention Action Plan 2025. The formative evaluation will occur once the action plan commences in order to identify any emerging issues with design and make improvements to how the action plan is implemented. A summative evaluation will be conducted after the Suicide Prevention Action Plan 2025 progresses to determine the extent to which the action plan has achieved, or contributed to, the intended outcomes. This is an important driver of accountability.



Appendix, Glossary and References



Appendix One

Western Australian Suicide Prevention Action Plan 2021 – 2025 Framework

Priority Areas		Evidence-informed Activities	Program/Service Outcomes	Community Outcomes	Population Outcomes
Vision: With the right systems and support suicide in Western Australia becomes preventable, with no-one who is in distress seeing suicide as their only option					
			SHORT & INTERMEDIATE TERM OUTCOMES		
			LONG TERM OUTCOMES		
Prevention <ul style="list-style-type: none"> Community engagement and awareness to support positive change Mental health and wellbeing education, and suicide prevention training for communities Responsible reporting of suicide in the media 			<ul style="list-style-type: none"> Increased literacy surrounding mental health and wellbeing and suicide prevention Decreased stigma associated with mental health issues and suicide Increased ability to seek help for oneself or for someone else Increased coping skills and ability to manage difficult life experiences 		
Intervention <ul style="list-style-type: none"> Options for people experiencing suicidal crisis Competent and confident assistance for people who are suicidal Restricting the means of suicide Appropriate aftercare support following a suicide attempt 		Training for professionals and para-professionals (first responders)	<ul style="list-style-type: none"> Improved care and support for individuals in crisis Improved care and support for those assisting individuals in crisis Improved functioning following crisis Decreased symptoms following crisis Decreased access to means for those in crisis Improved response to suicidal behaviours Increased quality of data on suicidal behaviours Increased timeliness of data on suicidal behaviours 	Increased personal and community resilience	<ul style="list-style-type: none"> Decreased instances of intentional self-harm in Western Australia Decreased deaths due to suicide in Western Australia
Postvention <ul style="list-style-type: none"> Support for people and communities affected by a suicide death Streamlined notification processes 		Building community capacity to respond to the needs of those affected by a suicide death Help seeking and help offering in communities	<ul style="list-style-type: none"> Improved care and support for those affected by a suicide Increased quality of data on suicide Increased timeliness of data on suicide 		
Aboriginal <ul style="list-style-type: none"> Support for community-driven social and emotional wellbeing, and suicide prevention in Aboriginal communities <i>Guidance is being sought regarding the most appropriate and culturally secure approaches to support suicide prevention in Aboriginal communities</i>					
Principles: <ul style="list-style-type: none"> Everyone has a role in suicide prevention Recognition that lived experience is essential to inform suicide prevention activity Community wellbeing and resilience are fundamental Evidence-informed, integrated, cross-sectoral approaches are needed Quality and timely interventions are available across the lifespan Earlier intervention to prevent and manage crisis 			<ul style="list-style-type: none"> Support and care is matched to individual needs and preferences Care is culturally appropriate and compassionate Approaches are tailored to local circumstances and priorities Communities are empowered to lead local efforts Individuals, families and communities are supported to recover A sustainable service system, which takes into account the limited resources available 		
Enablers: <ul style="list-style-type: none"> Better use of data, information and evidence to support suicide prevention Inclusiveness for all Western Australians, including those at increased risk Partnerships, collaboration, and coordination of activities for better outcomes Acknowledgment of the role that trauma and the social determinants of health have in suicide prevention 					

Appendix Two

Desktop review of strategic government documents with direct or indirect involvement in addressing suicide within WA

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6. Government of Western Australia, 2019. *Our Priorities: Sharing Prosperity*.
7. Kimberley Aboriginal Law and Cultural Centre (KALACC), 2019 (Draft), *KALACC Feedback on the 22nd May 2019 Statement of Intent on Aboriginal Youth Suicide*. KALACC May 2019.
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9. Mental Health Commission, 2019. *Full Government Response to the Western Australian Methamphetamine Taskforce Report*. Mental Health Commission, Government of Western Australia.
10. Mental Health Commission, 2019(a). *Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015-2025 (Plan) Update 2018*. Mental Health Commission, Government of Western Australia;
11. National Aboriginal and Torres Strait Islander Leadership in Mental Health (NATSILMH), 2015. *Gayaa Dhuwi (Proud Spirit) Declaration: A Companion Declaration to the Wharerātā Declaration for Use By Aboriginal and Torres Strait Islander Peoples*.
12. NATSILMH, 2017. *Co-Designing Health in Culture: Gayaa Dhuwi (Proud Spirit) Declaration Implementation Guide*.
13. National Mental Health Commission, 2019. *Monitoring Mental Health and Suicide Prevention Reform: National Report 2019*. NMHC Sydney;
14. National Suicide Prevention Project Reference Group (NSPPRG), 2019 (Draft). *National Suicide Prevention Implementation Strategy for Australia's Health System 2020-2023. Draft for Comment as at 12 August 2019*. Mental Health Principle Committee.
15. Sustainable Health Review, 2019. *Sustainable Health Review: Final Report to the Western Australian Government*. Department of Health, Western Australia.

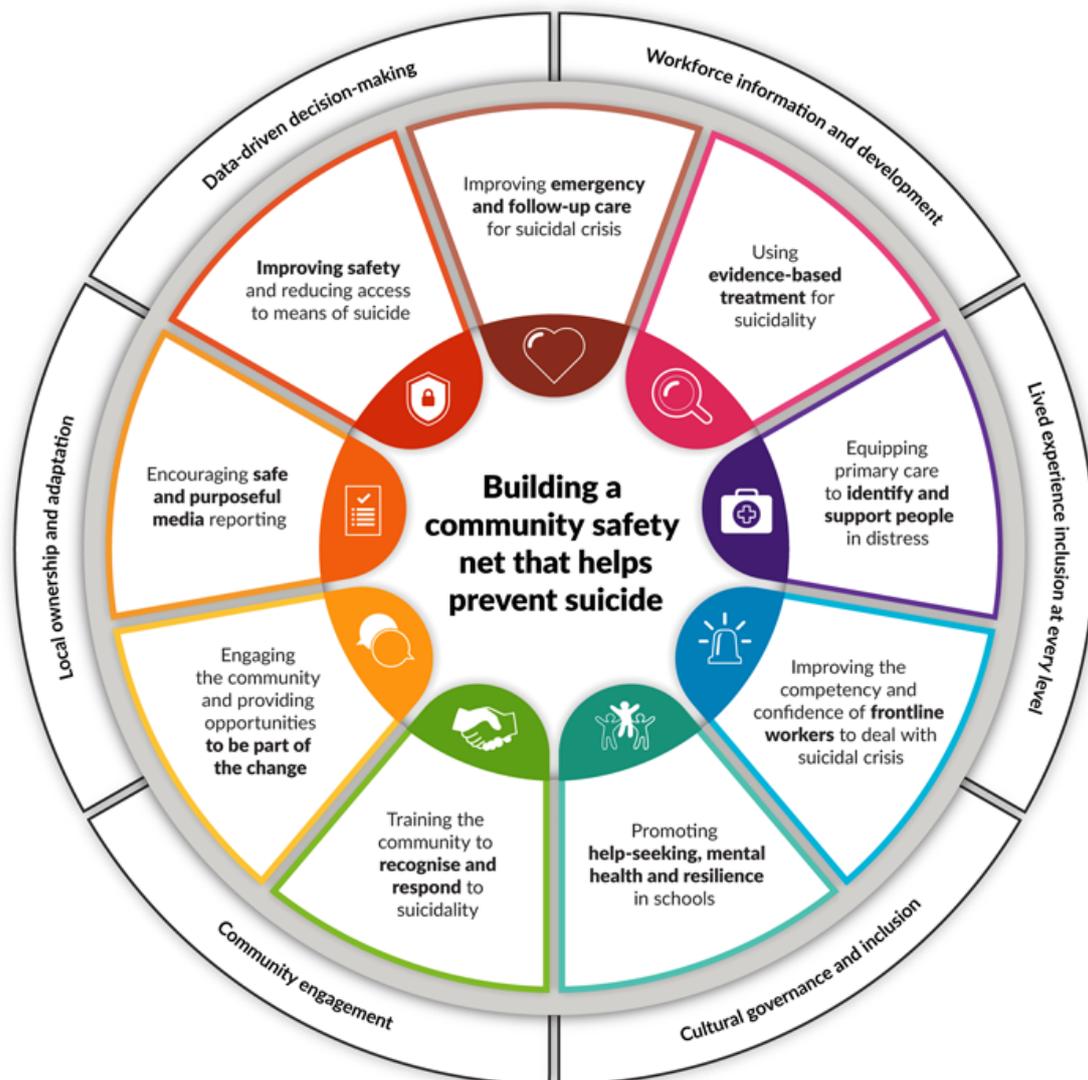
Appendix Three

Lifespan model

LifeSpan involves the implementation of nine evidence-based strategies simultaneously within a localised area. For each strategy, LifeSpan selects and implements the interventions or programs that have the strongest evidence-base.

These strategies are based on the most up-to-date evidence drawn from similar, large-scale suicide prevention programs overseas that have shown positive results.

This integrated systems approach is expected to prevent 21% of suicide deaths, and 30% of suicide attempts.



Appendix Four

Alliance Against Depression Framework



Appendix Five

Everymind Prevention First Framework

Focus	Domain	Target Groups	Definition	Examples
Actions to prevent onset of suicidal behaviour	Primary Prevention	Whole community or groups in the community	Interventions focus on reducing risk factors and enhancing protective factors in whole communities regardless of their level of risk. This also includes strategies to address specific social determinants and engaging communities in suicide prevention action (<i>universal intervention</i>).	Reducing access to means; Altering media coverage of suicide; Providing community education about suicide prevention; Creating stronger families; Addressing community connectedness and the social determinants of health and wellbeing.
		Groups or individuals with higher risk	Interventions focusing on reducing risk factors and enhancing protective factors to prevent the onset of suicidal behaviour in groups known to be at increased risk (<i>selective intervention</i>).	Programs that empower, support and build skills in groups at higher risk of suicide. These may include: people who have attempted suicide, in detention, recently discharged from hospital, living with chronic pain, recently unemployed or experiencing a life crisis.
Actions to intervene early and effectively to reduce suicide	Secondary Prevention and Early Intervention	Individuals showing early signs of suicidal behaviour	Early identification of individuals showing signs of suicidal behaviour and clear pathways to appropriate services and other support (<i>indicated intervention, detection</i>).	Gatekeeper training to assist people to detect the early signs of suicidal behaviour (including GPs, schools, workplaces and community services); Building pathways for self-help; Referral pathways between community organisations, primary care and specialist services.
		Individuals experiencing a suicidal crisis	Evidence-based treatments and interventions to lower the severity and duration of a suicidal crisis and/or attempt (<i>accessing support, treatment</i>).	Providing integrated professional care; Workforce development for frontline health, mental health and emergency services staff; E-therapies; Effective community follow-up after a suicide attempt.
Actions to lower the impact of suicide	Postvention	Individuals and communities affected by suicide	Interventions focused on supporting individuals, families and communities affected by a suicide death.	Practical and psychological support for people bereaved by suicide; Effective communication about suicide to reduce risk to others affected by or exposed to the death.
Actions to promote wellbeing	Promotion of Wellbeing	Individuals with lived experience of suicide or suicidal behaviour	Interventions to enhance social, emotional and spiritual wellbeing and quality of life for people affected by suicide. Initiatives can occur within services or in the community (<i>ongoing care and support</i>).	Psychoeducation and support programs for families and friends of those who have attempted suicide; Self-help, skills building and peer support for those with lived experience of suicidal behaviour.
		Whole community or groups in the community	Interventions to enhance social, emotional and spiritual wellbeing and quality of life. Initiatives can occur with the whole population, or selected groups, and can occur in any setting (including schools, workplaces, the home etc.).	Ensuring safe communities, social inclusion, access to housing, transport, education and other essential services; Evidence-based strategies to build resilience in early childhood, schools, workplaces etc.

Glossary

Key terms and preferred language when taking about suicide are explained below.

Aftercare

The care, treatment, help, or supervision given to persons following a suicide attempt. It can include hospitalisation or medical treatment. Aftercare is important for family and carers, because a suicide attempt is the strongest risk factor for subsequent suicide, and the highest risk period is shortly after release.

Attempted suicide

Attempted suicide refers to any non-fatal suicidal behaviour. In some cases it can be difficult to determine if a person intended their actions to result in death.

Impacted by suicide

An individual impacted by suicide may experience a variety of responses on a broad continuum – from immediate, short term emotional response, to long term, profound distress. (Maple et al. 2016)

Intentional self-harm

Engaging in an act of self-harm with the intention of suicide. Intentional self-harm will result in either a non-fatal suicide attempt or a suicide death.

Lived experience

having experienced suicidal thoughts, survived a suicide attempt, cared for someone through suicidal crisis, or been bereaved by suicide

Mental health promotion

Involves actions to create living conditions and environments that support mental health and allow people to adopt and maintain healthy lifestyles.

Mental illness prevention

Initiatives which focus on reducing risk factors for mental ill-health and enhancing protective factors.

Non-Suicidal Self Injury (NSSI)

Engaging in an act of self-injury without the intention of it resulting in suicide. Although suicide is not the intention of NSSI, there is an independent association between NSSI and increased suicide risk.

Primary Prevention

Strategies aimed at preventing illness by maintaining and/or enhancing the wellbeing of the general population.

Secondary Prevention/Intervention

Seeks to lower the number of cases of a disorder or illness in the population through early detection and treatment.

Stigma

The WHO defines stigma as a major cause of discrimination and exclusion: it affects people's self-esteem, helps disrupt their family relationships and limits their ability to socialise and obtain housing and jobs.

Suicide

A death resulting from an act of deliberate self-harm, with the belief the action will be likely to cause death and with the intention of ending one's own life.

Suicidality

Thoughts and behaviours related to suicide.

Suicidal crisis

A situation in which an individual is engaging in intentional self-harm with intent to die, or is seriously contemplating or planning to make an attempt on their own life.

Suicidal ideation

Suicidal thoughts, or suicidal ideation, means thinking about or planning suicide. Suicidal ideation can range from momentary passing thoughts of ending one's own life to extensive contemplation and detailed planning.

Suicidal behaviour

Engaging in actions that have the potential to lead to suicide. Suicidal behaviour can range from role playing an intended suicide to making an attempt.

Tertiary Prevention/Postvention

Interventions that reduce disability enhance rehabilitation and prevent reoccurrences of the illness.

Vulnerable Populations

Refers to those populations who have a higher risk of suicide

and suicidal behaviour than the general population. These include: Aboriginal people; persons who have experienced abuse, trauma, conflict or disaster; refugees and migrants; prisoners and others in contact with the justice system; lesbian, gay, bisexual, transgender and intersex persons (LGBTI); frontline workers, individuals who have had a previous attempt and people suicide bereaved.

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Needing help?

In an emergency call 000 or visit your local emergency department

Mental Health Emergency Response Line (MHERL)

1300 555 788 (Perth Metro Residents)

1800 676 822 (Peel Residents)

Available 24/7

RuralLink

Telephone: Freecall 1800 552 002

Available 4.30pm - 8.30am Monday to Friday and 24 hours Saturday, Sunday and public holidays. During business hours you will be connected to your local community mental health clinic.

Lifeline

Telephone: 13 11 14

Available: 24/7

lifelinewa.org.au/

Kids Helpline

Telephone: 1800 551 800 (free call)

Available: 24/7

kidshelpline.com.au

MensLine Australia

Telephone: 1300 78 99 78

www.mensline.org.au

Suicide Call Back Service

Telephone: 1300 659 467

Available: 24/7 across Australia

Website: suicidecallbackservice.org.au

Samaritans Crisis Support

Telephone: 135 247

Available: 24/7

Other services that can provide assistance for people having thoughts of suicide include

Headspace

1800 650 890

www.headspace.org.au

QLife

Telephone: 1800 184 527

Available: 3.00pm-midnight, everyday

qlife.org.au

beyondblue

Telephone: 1300 224 636

Available: 24/7

beyondblue.org.au

Carers Australia WA

Telephone: 1800 Carers (1300 227 377) (free call)

Available: 8.30am – 4.30pm

Counselling Line: 1800 007 332 (free call)

Available: 8.30am – 7.30pm

MATES In Construction

1300 642 111

www.matesinconstruction.org.au/wa/

If you are bereaved by suicide and need help, the following service are able to assist

Suicide Call Back Service

1300 659 467

www.suicidecallbackservice.org.au

Children and Young People Responsive Suicide Support

1300 114 446

www.cypress.org.au

Active Response Bereavement Outreach (ARBOR)

1300 11 44 46

Lifeline

13 11 14

www.lifelinewa.org.au

Stand By – support after suicide

ww.standbysupport.com.au



Government of **Western Australia**
Mental Health Commission



GPO Box X2299, Perth
Business Centre WA 6847

Level 1, 1 Nash Street,
Perth, WA 6000

T (08) 6553 0600
mhc.wa.gov.au

