Queensland Suicide Prevention

Action Plan 2015-17

Queensland Mental Health Commission

Queensland Government

Seek help

National 24/7 crisis services

Lifeline 13 11 14

Suicide Call Back Service 1300 659 467

MensLine Australia 1300 78 99 78

Kids Helpline 1800 55 1800 (24/7 crisis support)
or www.kidshelp.com.au

National support services

General support

***beyondblue* support service**
1300 22 4636 or email/chat at www.beyondblue.org.au

Lifeline www.lifeline.org.au/Get-Help/

Suicide Call Back Service
www.suicidecallbackservice.org.au

SANE Australia Helpline
1800 18 SANE (7263) www.sane.org

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Minister for Health and Minister for Ambulance Services

The Queensland Government is committed to reducing suicide and its impact on Queenslanders. Every year more than 600 Queenslanders take their own lives and many more attempt suicide. The impact of these tragic events has a ripple effect within families, workplaces, communities and across Queensland.

Suicide is a profoundly challenging and complex issue. There is no single solution, service or initiative that will reduce suicide and its impact.

It requires all of us to play a role and share responsibility to support those at risk, their families and communities. There are many actions we can take, on many levels and across many fronts that can help us prevent and reduce the incidence of suicide.

Strengthening the public health system response to suicide attempts and those at risk will go only some way to reducing suicide and its impact. We need to recognise that every interaction with every service presents an opportunity to provide support.

I am pleased to present this *Queensland Suicide Prevention Action Plan 2015-17*.

It outlines actions across the State Government to improve our responses to people at risk of suicide and to support families, communities, service providers and first responders who are impacted by suicide.

Importantly, this Action Plan adopts a multi-faceted approach to suicide prevention that involves and includes the whole community. I would like to thank my State Government colleagues for their commitment to addressing this important issue and committing to actions outlined in this Action Plan.

The Honourable Cameron Dick MP
Minister for Health and Minister for Ambulance Services

Foreword

Queensland Mental Health Commissioner

Suicide, tragically, occurs across all age groups and all walks of life. One death by suicide is one too many.

On the surface, suicide may appear to be a tragic personal matter, yet each suicide affects the lives of many, including family, friends, classmates, co-workers and others across the community. It is a terrible toll that we must reduce.

The Commission has had the privilege of talking to many Queenslanders, including those who have been impacted by suicide, about what actions we, as a state and a community, might take to reduce suicide.

Overwhelmingly the message has been that we need to 'change the conversation' to one that focuses on hope and optimism for the future, to break down the barriers that prevent people seeking help and provide more information to communities and service providers about how to support those at risk of suicide. They also told us of the need to look beyond the health system to the broader social service system as providing opportunities for improved support and earlier intervention.

The commitment of so many people and government agencies in reducing suicide is evident in this Action Plan.

Suicide is everybody's business and together we can respond better, to provide support to those who need it, and to work towards preventing situations from reaching a crisis point.

I would like to acknowledge the strength and courage of those affected by suicide in sharing their stories and experiences with us and for guiding the development of this Action Plan.

It is a plan about people, about reaching out and making a difference, and about bringing hope and support to those who need it.

Dr Lesley van Schoubroeck
Queensland Mental Health Commissioner

Executive summary

Suicide affects people of all ages and all walks of life. Over 600 Queenslanders take their own lives each year. The impact of these tragic events is felt across our State by families, communities and service providers including first responders.

The *Queensland Suicide Prevention Action Plan 2015-17* (this Action Plan) aims to reduce suicide and its impact on Queenslanders. It is a step towards reducing suicide by 50 per cent within a decade.

Reducing suicide and its impact will require leadership and action from all parts of our community at all levels, including government and non-government service providers. This Action Plan acknowledges the important role of the health system but extends to realising opportunities presented through other services and sectors to support those at risk, and those who have attempted suicide, their families and communities.

It has been developed having regard to data about suicide rates; research about what works; the national context; and consultation with key stakeholders including those impacted by suicide, researchers, non-government service providers and State Government agencies.

This Action Plan outlines actions under four priority areas:

1. **Stronger community awareness and capacity** so that families, workplaces and communities are better equipped to support and respond to people at risk of, and impacted by, suicide.
2. **Improved service system responses and capacity** to ensure people at risk, including those who have attempted suicide, get the support they need, when and where they need it.
3. **Focused support for vulnerable groups** to address the specific needs of groups and communities experiencing higher rates, and at greater risk, of suicide.
4. **A stronger more accessible evidence base** to drive continuous improvement in research, policy, practice and service delivery.

There are many suicide prevention programs and initiatives underway across Queensland led by industry, government and non-government organisations. The actions in this Action Plan build on what is currently being implemented and includes innovative approaches to suicide prevention to further reduce suicide and its impact.

Implementation of the Action Plan will be overseen by a Queensland Suicide Reference Group convened by the Queensland Mental Health Commission (the Commission) and involving government and non-government organisations, including organisations representing those who have been impacted by suicide. A report on implementation will be publicly released as part of the *Queensland Mental Health, Drug and Alcohol Strategic Plan 2014–2019's* Annual Report each December.

Although significant changes in the suicide rate will take time and will be influenced by many factors, suicide rates in Queensland, and for particular vulnerable groups, will be monitored and reported.

The Commission will review the Action Plan after 12 months to ensure it continues to complement national approaches to suicide prevention and is based on the most contemporary evidence of what works.

Many of us experience good lives enriched with positive connections with family, friends and the community, a sense of purpose and meaning, and optimism about the future. However, the challenges of daily living, including experiences of stress, loss and other trauma can test our ability to cope.

Over 600 Queenslanders, of all ages and from all walks of life, take their own lives each year[1]. Every suicide has a ripple effect, impacting families, friends, work colleagues and the whole community.

While not all suicides are preventable, increasing individual and community capacity and resilience and supporting individuals and communities at risk to seek and receive help can reduce the number of people taking their lives.

Over the past 20 years successive state and federal governments have prioritised suicide prevention and recognised it as a significant public policy issue. Our understanding of suicide prevention and effective responses to suicide risk and vulnerability has increased substantially during this time. The mental health and wellbeing of those who are bereaved and impacted by suicide has also received greater attention.

To continue this work a renewed, whole-of-government approach is needed that supports whole-of-community action to reduce suicide and improve access to support for people, families and communities impacted by suicide.

Our shared goal

This Action Plan aims to reduce suicide and its impact on Queenslanders and is a step towards achieving a 50 per cent reduction in suicides in Queensland within a decade.

About this Action Plan

The *Queensland Mental Health, Drug and Alcohol Strategic Plan 2014–2019* (the Strategic Plan) aims to improve the mental health and wellbeing of Queenslanders, and commits to developing a renewed approach to suicide prevention for Queensland.

This Action Plan outlines this renewed approach and includes actions with a specific focus on suicide prevention and providing support for those impacted by suicide.

It acknowledges that broader issues such as improving mental health and wellbeing and preventing and reducing the adverse impact of problematic alcohol and drug use are central to achieving our shared goal. This Action Plan is supported by other action plans being developed as part of the Strategic Plan, including:

- The Queensland Mental Health Promotion, Prevention and Early Intervention Action Plan to improve mental health and reduce the incidence, severity and duration of mental health problems and mental illness.
- The Queensland Alcohol and other Drugs Action Plan to prevent and reduce the adverse impact of alcohol and drugs on Queenslanders.
- The Queensland Aboriginal and Torres Strait Islander Social and Emotional Wellbeing Action Plan to improve social and emotional wellbeing.
- The Queensland Rural and Remote Mental Health and Wellbeing Action Plan to improve the mental health and wellbeing of people living in rural and remote communities.

This Action Plan has been informed by research about what works to reduce suicide and its impact including evaluations of services and initiatives; an analysis of data about suicides in Queensland; the views of key stakeholders and those who have been impacted by suicide; and national policies, programs and services.

This Action Plan has been developed taking into account the diversity of programs, services and initiatives that have, and are, contributing to preventing suicide and supporting those impacted by suicide in Queensland.

The actions in this Action Plan build on what is currently being implemented and include innovative approaches to suicide prevention.

Suicide and its impact on Queenslanders

In 2014, an estimated 627 people in Queensland took their lives[2]. While suicide rates have remained relatively stable in Queensland at around 13.3 per 100,000 people between 2009–2013, they continue to be higher than the national rate of 10.9 per 100,000 people and higher than the rates in most other states and territories[3].

Figure 1: Suicides by state and territory between 2009–13
(age standardised rate per 100,000)[4]

State/Territory	Rates
Northern Territory	17.6
Tasmania	14.0
Western Australia	13.4
Queensland	**13.3**
South Australia	11.9
Victoria	9.4
New South Wales	9.1
Australian Capital Territory	9.1
National	10.9

According to the Australian Institute for Suicide Research and Prevention one third (31.2 per cent) of people who died by suicide in Queensland between 2002 and 2011 had previously attempted suicide[5]. For every person who dies by suicide, an estimated 30 people attempt suicide[6] with a higher proportion of women attempting suicide than men. Between 1999 to 2012 hospitalisation rates for females due to intentional self-harm, with and without suicidal intent, were at least 40 per cent higher than rates among men[7].

The impacts of suicide are immediate, far-reaching and long-lasting. They are felt by families, friends, work colleagues and the broader community, who may struggle to support a person experiencing suicidal behaviour or to cope with the aftermath of a suicide. The number of people impacted by suicide is difficult to quantify, with one study finding that for every suicide six people identify as being bereaved by suicide[8].

There are also significant impacts on service providers, particularly those providing support and treatment, and first responders such as police and ambulance officers.

The impact of suicide also translates to a substantial economic cost. A conservative estimate of the national economic cost of suicide and suicidal behaviour is $17.5 billion ever year[9]. This cost has been calculated based on years of life lost, lost productivity including among survivors, as well as the cost to services and of suicide prevention activities.

Although suicide affects people from all walks of life and of all ages, some groups and communities experience higher rates and are at greater risk of suicide including men, Aboriginal and Torres Strait Islander people, people living in rural and remote communities and Lesbian, Gay, Bisexual, Transgender and Intersex people. Others are at greater risk at certain times and in certain circumstances, for example seniors and children and young people who are known to child safety services.

The factors that influence suicidal behaviour

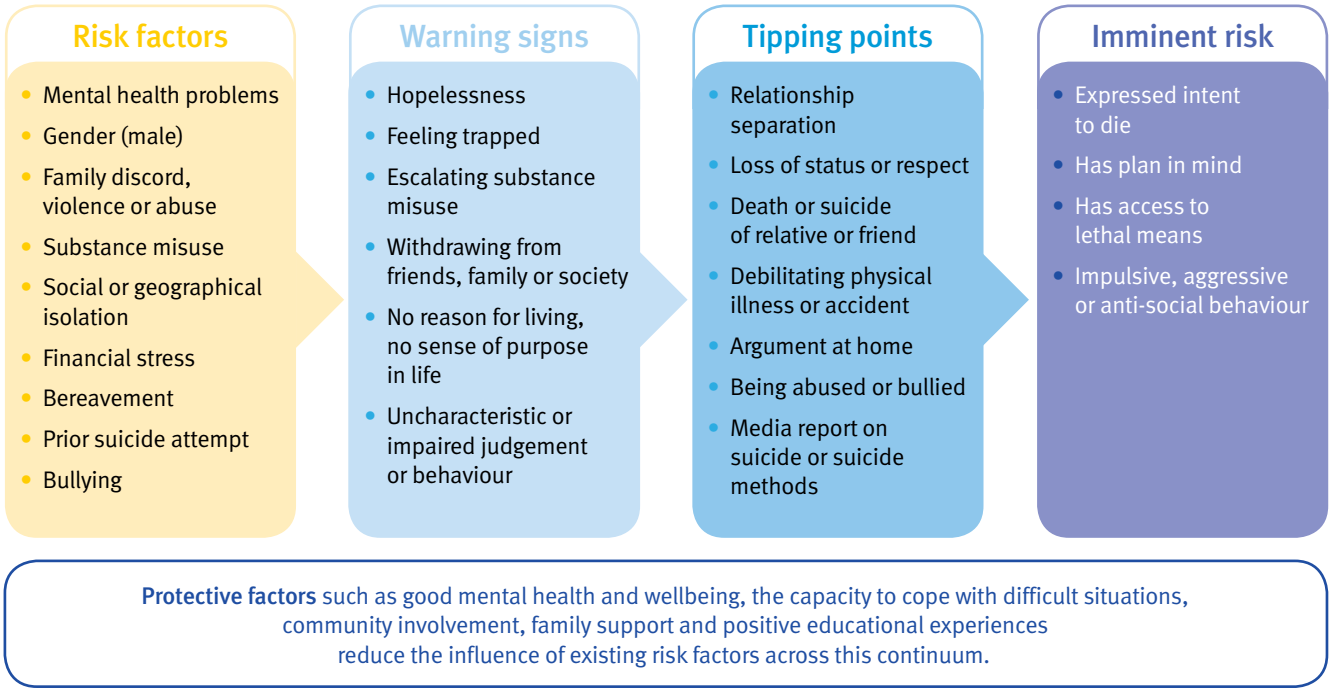
Although suicide is increasingly understood to be preventable, the ability to accurately predict future suicide is extremely difficult. There is no single factor that contributes to suicide, suicidal ideation or suicide attempts. Rather, suicidal behaviour is best understood as a complex interaction between a range of protective and risk factors during a person's life.

Protective factors reduce the likelihood of suicidal behaviour occurring and enhance an individual's resilience and capacity to cope with difficult circumstances and life stresses[10]. Risk factors increase the likelihood of suicidal behaviour and may place some people, at certain times in their lives, at greater risk. For example a previous suicide attempt is a known risk factor and one of the most significant indicators of a future suicide.

The relationship and interaction between protective and risk factors does not explain everything about suicidal behaviour. Not everyone who is experiencing risk factors will suicide or attempt suicide. Instead these factors are best understood as interacting to influence the vulnerability of different people, groups and communities at different points of time.

Although a person may be experiencing risk factors and be showing warning signs of suicide, it is usually one or two tipping points such as job loss or relationship breakdown that may lead to imminent risk of suicide (as outlined in Figure 2). For example between 2002 and 2011 in Queensland, 22.6 per cent people who died by suicide had experienced a relationship breakdown and separation and 12.7 per cent experienced relationship conflict. Financial problems were identified in 12.7 per cent of suicides in Queensland and recent or pending unemployment in 7.4 per cent[11].

Figure 2: The interaction between different risk and protective factors, tipping points and precipitating events



Sourced from the National LIFE: Living is for everyone framework

Reducing suicide and its impact in Queensland

To effectively reduce suicide and its impact actions are needed which:

- promote protective factors and reduce the influence of risk factors at the individual, social, economic and environmental level
- improve the identification, management and support provided to those who are at risk, showing warning signs and experiencing tipping points
- support vulnerable communities and groups by tailoring actions to address their unique circumstances and needs.

Actions should be taken in three inter-related areas:

- **Prevention** activities that include public education, community awareness or training programs, as well as addressing the social determinants of mental health and wellbeing through sectors working closely together, for example housing, education and employment.
- **Intervention** activities that focus on responding directly to an individual's immediate suicide risk, such as gatekeeper training, screening and detection of suicidal thoughts or behaviour in general community and health settings, as well as clinical/social support to individuals who attempt suicide.
- **Postvention** activities that respond to a suicide, for example bereavement support provided to families and friends or programs that assist communities to respond to or recover from a suicide. They also seek to prevent contagion of suicidal behaviour, where a suicide may influence suicidal behaviour in others, particularly among vulnerable individuals or communities, and reduce the potential of a suicidal cluster, where multiple suicides occur in a defined region or within a certain timeframe[12].

As outlined in Figure 3, best practice approaches to suicide prevention are implemented through a continuum of activities across eight areas, from population level prevention, to treatment of at risk individuals through to continuing care for those at immediate risk of harm or who have attempted suicide.

There is increased recognition of the value of ensuring that the views and perspectives of people who have a 'lived experience' of suicide are incorporated into policy, practice and research to better understand how to prevent suicide. Suicide Prevention Australia defines 'lived experience' as 'having experienced suicidal thoughts, survived a suicide attempt, cared for someone who has attempted suicide, been bereaved by suicide, or been touched by suicide in another way'[13].

Figure 3: Continuum of best practice suicide prevention activities as outlined in the LIFE Framework[14]

Universal intervention	
Whole-of-population interventions to reduce the means of suicide, to reduce the negative stigma of suicide and to improve the resilience of individuals, families and communities	**Applies to everyone:** involves individuals, families, local councils, community organisations, workplaces, schools, sporting clubs
Selective intervention	
Interventions for identified at-risk groups to build resilience, strength and capacity as well as an environment that promotes self-help and access to support	**For groups at risk:** involves individuals, families, local councils, GPs, schools, workplaces, sporting clubs
Indicated intervention	
Identification, intervention and support for people showing signs of, or at risk of, suicide	**For individuals at high risk:** involves families, GPs, police, specialists, workplaces, schools
Detection	
Being alert to warning signs and potential tipping points, and providing support and care	**When vulnerability is high:** involves families, GPs, helplines, emergency services, teachers
Accessing support	
Finding and accessing early care and support when treatment and specialised care is needed	Involves GPs, psychologists, allied health, Aboriginal health workers, police, emergency departments
Standard treatment	
Integrated professional treatment, management and recovery when needed	Involves psychiatrists, psychologists, GPs, Aboriginal health workers, allied health
Longer term treatment and support	
Ongoing integrated care that consolidates recovery and reduces the risk of adverse health effects	Involves psychiatrists, psychologists, GPs, allied mental health, families, friends, community organisations
Ongoing care and support	
Building strength, resilience and coping strategies, as well as an environment that supports help-seeking	Involves GPs, allied health, community organisations, local service providers, families, friends

National context

The Australian Government plays a very significant role in suicide prevention initiatives through the National Suicide Prevention Strategy (NSPS) which includes the LIFE Framework[14] and the National Suicide Prevention Programme (NSPP). Endorsed by the Council of Australian Governments, the LIFE Framework sets the overarching national policy framework for suicide prevention activities with a focus on early intervention and prevention.

The NSPP is a dedicated suicide prevention funding program that supports activities across the Australian population and for specific at-risk groups including men, Indigenous people, rural and remote communities, people bereaved by suicide, people with a mental illness and young people.

The NSPP was considered in the National Mental Health Commission's *National Review of Mental Health Services and Programmes 2014* (the National Review). The National Review recommended that future effort focuses on reducing suicide and suicide attempts nationally by 50 per cent over the next decade.

In particular the National Review recommends that the Australian Government develop, agree and implement a *National Mental Health and Suicide Prevention Plan* with States and Territories, in collaboration with people with lived experience, their families and support people; and establish 12 regions across Australia as the first wave for the nationwide introduction of sustainable, comprehensive, whole-of-community approaches to suicide prevention (recommendation 19).

An Expert Reference Group has been established to consider the National Review's findings and recommendations and provide advice to the Australian Government on its response.

What we heard

To develop a renewed approach to suicide prevention in Queensland, the Queensland Mental Health Commission hosted three Strategic Conversations involving key stakeholders and people with a lived experience of suicide in March and April 2015.

The Commission also undertook targeted consultations and broader public consultation through the release of a discussion paper in July 2015.

The Strategic Conversations identified and agreed on this Action Plan's shared goal and identified the four priority areas that underpin the renewed approach to suicide prevention.

Key themes that emerged from the Strategic Conversations included the need to:

- focus on strengthening protective factors and social conditions that support good mental health and wellbeing, including the significant role that communities play in suicide prevention
- strengthen the ability of families, colleagues, peers and the community to safely talk about, and respond to, suicide and suicide risk
- enhance the availability, suitability and accessibility of services for people at risk
- better use of available suicide data and information to more effectively inform community and service responses
- increase practical guidance and access to information about what initiatives work, when, where and for whom.

Many indicated that there was a need to 'change the conversation' about suicide prevention in Queensland from a sense of hopelessness towards a life with meaning; and at a practice and service level from a focus on clinical diagnosis to supporting a person in crisis, by taking into account the holistic needs of those at increased risk.

The Commission sought the views of Queenslanders on the shared goal and priorities and received 36 responses from a wide range of organisations and people including those bereaved and impacted by suicide and non-government organisations who provide support and suicide prevention initiatives.

Stakeholders strongly indicated that although there is a diversity of suicide prevention activities currently being undertaken across the State, greater alignment and coordination is required to reduce duplication and identify areas of unmet need. To be effective, coordination is required at the community level and between state and national services and initiatives. Specific feedback relating to the priority areas and actions is outlined throughout this Action Plan.

Our shared priorities

The consultation results identified four priority areas to implement a renewed approach towards reducing suicide and its impact on Queenslanders. Also based on research and evidence of what works, this Action Plan outlines actions under four priority areas:

1. **Stronger community awareness and capacity** so that families, workplaces and communities are better equipped to support and respond to people at risk of, and impacted by, suicide.
2. **Improved service system responses and capacity** to ensure people at risk, including those who have attempted suicide, get the support they need, when and where they need it.
3. **Focused support for vulnerable groups** to address the specific needs of groups and communities experiencing higher rates, and at greater risk, of suicide.
4. **A stronger more accessible evidence base** to drive continuous improvement in research, policy, practice and service delivery.

These priority areas relate to each other with some actions supporting more than one priority.

Priority Area 1:

Stronger community awareness and capacity

Our purpose

To build stronger and more supportive families, workplaces and communities so they are better equipped to support and respond to people at risk of, and impacted by, suicide.

Why is this important?

The community we belong to can take many forms – it can be the people we live with in a town or suburb and it can be a group of people we share a common background or interest with.

Our connections to these communities as well our connections to supportive families, schools and workplaces is important for our overall mental health and wellbeing and enhances our capacity to cope with the challenges of daily living. They are also an important protective factor that may reduce a person's vulnerability to suicide. Communities therefore play an important role in supporting inclusion.

Over the longer term, strategies that build individual and community capacity and resilience, and address underlying social factors that may lead to increased risk, have the potential to prevent issues from arising or escalating to a point of crisis. Actions undertaken in this priority area will be complemented by activities undertaken under the Queensland Mental Health Promotion, Prevention and Early Intervention Action Plan.

Communities, families, schools and workplaces can also play a significant role in supporting and responding to those at risk of suicide including people who have attempted suicide. Those consulted by the Commission indicated that many people and communities feel they lack the knowledge, skills and confidence to recognise, and safely respond to, a person who may be at higher risk of suicide.

Although people at risk of suicide may show warning signs such as withdrawing from friends and family or demonstrating a sense of hopelessness, they do not always openly discuss these feelings or thoughts. Equipping individuals, families, work colleagues, peers and communities with the skills and capacity to recognise and assist a person at risk of suicide, their families and support persons, is an important way to ensure more people get the help they need, when they need it.

The impact of suicide on those who are bereaved, including family and friends, is significant and affects their mental health and wellbeing. Suicide can also significantly impact communities. One of the impacts of suicide is the risk of contagion where a suicide may influence suicidal behaviour in others or suicide clusters where multiple suicides occur in a defined region and within a certain timeframe.

What works and what is needed?

Consultations identified the need for grass roots community action and the need for local level leadership to drive community suicide prevention activities. This should be supported by community engagement strategies to improve the accessibility, sustainability, effectiveness and uptake of suicide prevention initiatives[15]. Providing appropriate information and resources designed to assist local communities to implement suicide prevention activities is also required.

Informal networks through community members, families and friends can play an invaluable role in assisting people at risk. However, responding to someone who is contemplating suicide or is at risk of suicide can be difficult. To respond effectively and safely, communities, families, schools and workplaces need assistance, guidance and support.

Helping someone who is at risk of suicide can be complicated by issues relating to stigma that may prevent a person from seeking help[16]. This includes stigma associated with suicide, but also with those issues that contribute to suicide risk, such as financial hardship, relationship breakdown, homelessness and mental illness[17].

Reducing stigma by improving our understanding of these issues has the potential to encourage people to talk about their thoughts and feelings, as well as seek and access support and assistance when they need it. Consultations indicated that actions to reduce stigma should occur not only within the broader community but also among service providers. For example having negative experiences of services when help was previously sought may stop someone from accessing that type of support again[18]. This is compounded when working with vulnerable groups such as Aboriginal and Torres Strait Islander people, or refugees and asylum seekers who may not openly engage with services because previous experiences with government organisations has led to a distrust of these agencies.

Many stakeholders indicated that there is a need for our community, as a whole, to talk more openly about suicide. These conversations are needed however they need to be based on accurate information. For example, research indicates repeated and continual coverage or publicity about suicides in the media and public domain may induce and promote suicidal ideation, and increase the risk of suicidal behaviour in vulnerable individuals or groups[19]. There have been significant improvements in this area with the development of media guidelines, through the national *Mindframe* initiative, which aim to provide access to current, evidence-based information to support appropriate reporting, portrayal and communication about suicide and mental illness.

Support and assistance also needs to be available for people and communities who are bereaved by suicide, to help them manage the grief and trauma associated with their loss. Not only should this assistance focus on supporting a person to recover but also on minimising the risk of contagion or suicide clusters[20].

There are many resources and tools available to support communities and families. However those consulted indicated that there needed to be increased promotion to enable greater awareness of, and access to, these resources. Those consulted also indicated that resources may need to be tailored to meet the needs of particular communities and age groups.

Providing services and support to people experiencing suicidal ideation and people who have attempted suicide can have a significant professional and personal impact, including where a client has died by suicide. As the Senate Community Affairs Reference Committee's 2010 report *The Hidden Toll: Suicide in Australia* highlighted, the impact of attending traumatic or stressful situations on police and emergency services personnel is significant. Stakeholders provided evidence and submissions to the Senate Inquiry indicating that these experiences may result in vicarious trauma, stress-related anxiety, depression and post-traumatic stress disorders[21]. Working with clients who are at risk of suicide or attempted suicide, is one of the most frequently encountered emergency situations, and also one of the most anxiety provoking for many mental health service providers and clinicians[22], particularly if the client subsequently takes their own life.

Appropriately supporting workers who come into contact with people at risk is an important component of reducing the impact of suicide. Support needs to be tailored to the different settings and services and requires leadership from organisational leaders and managers.

Our focus

Priority Area One focuses on actions that aim to:

- **Promote community leadership by supporting local level solutions** to enhance community connectedness and engagement.
- **Raise community awareness** about suicide to ensure that individuals, families and communities have the capacity to have safe conversations about suicide and recognise and help a person at risk of suicide.
- **Reduce stigma** associated with suicide and other related issues such as mental illness and financial problems, to remove barriers to people seeking the support they need, when they need it.
- **Support and help those bereaved and impacted by suicide**, including families, communities, service providers and first responders to assist them in managing the impact of suicide and suicide attempts.

Significant actions to support a renewed focus

- **A Strengths-Based Community Development Approach to Suicide Prevention.** The Commission has funded the development of a Strengths-Based Community Development Approach to Suicide Prevention. With a focus on genuine community engagement at all stages of planning, this project aims to build upon existing community level suicide prevention activities, community infrastructure and strengths to enhance a community's responsiveness to local need. This project will be trialled in up to two sites in rural Queensland in early 2016 (Queensland Mental Health Commission).
- **Mates in Construction Scoping Project *'Saving lives in the Construction Industry'*.** Funding has been provided to Mates in Construction to scope the expansion of its suicide prevention initiatives to rural and regional Queensland and to include small and medium sized businesses. This project will examine and provide recommendations on future priorities and sustainable funding options for effective 'wrap around' services for suicide prevention and postvention in the construction industry (Queensland Mental Health Commission).

Good Practice Spotlight
Conversations for Life

Conversations for Life is an innovative program designed by Lifeboat that aims to open up conversations around suicide prevention between individuals, their families, friends and the community.

Lifeboat is a consortium of ConNetica, the OzHelp Foundation and Hope for Life (the Salvation Army) who have joined together to co-develop suicide prevention programs which are relevant for all Australians.

Conversations for Life is a half day program, that is tailorable to different contexts, and aims to build personal and community connections through conversation. It is designed to raise awareness about the nature and risk of suicide through debunking social myths, building practical conversation skills for participants in discussing well-being and providing early intervention support, as well as in identifying suitable referral and support options. It focuses not just on assisting those at imminent risk of harm, but also on how broader community groups and individuals can become more confident in engaging in meaningful conversations about life stressors and difficult times. With accreditation from the Pharmacy Guild of Australia and ACT Teachers, the program has recently been independently evaluated by the Australian National University. The evaluation demonstrated significant improvements in participants' confidence and willingness to have conversations about suicide.

Priority Area 2:

Improved service system responses and capacity

Our purpose

To ensure people at risk, including those who have attempted suicide, get the support they need, when and where they need it.

Why is this important?

Research indicates that many people do not seek support through mental health services when they are experiencing suicidal ideation or behaviour[23]. Instead they may have contact with, or seek assistance from, other services including hospitals, primary health care, allied health services, education, police, corrections, child protection, legal services and financial counsellors.

While health and mental health services provide important support to those at risk and those who have suicided, as noted by the State Coroner in findings for the *Inquest into the deaths of JE and JJ*, interactions with many of these government services present opportunities to intervene early and prevent a suicide from occurring. This principle extends to the community and private sectors that also come into contact with people at risk of suicide.

Although these services may have different responsibilities they play a critical role in identifying and responding to people at risk. They also play a very significant role in enhancing protective factors and addressing many of the underlying risk factors associated with suicide and suicidal behaviour.

Those consulted by the Commission indicated that there was also a need to improve the response of health services, in particular a need to focus on better discharge planning and clinical assessments of people who have presented at imminent risk of harm, or who have attempted suicide.

There is also a need to continue efforts to reduce access to lethal means as part of a comprehensive response to suicide prevention. People who experience suicidal ideation or intention are more likely to end their lives if they have access to the lethal means to do so[24].

What works and what is needed

Ensuring a responsive service system includes equipping service providers and other workers with the necessary skills and knowledge to be able to identify and respond to those at risk, as well as enhancing the capacity and capability of mental health and other services to respond to referrals and provide appropriate assessment, management and follow-up support.

This can be achieved through gatekeeper training, which focuses on building the knowledge and skills to enable service providers to be willing, ready and able to respond to someone at risk of suicide.

Consultations undertaken to inform this Action Plan identified issues in relation to accessing appropriate care for people experiencing suicidal ideation or who had attempted suicide, their families, carers and other support persons.

For example, for people experiencing a situational crisis that is not related to a mental illness, finding and accessing appropriate support was identified by those consulted as being at times very difficult. In these situations people at risk may not meet the clinical criteria for admission to a mental health service, and as a result end up 'falling through the gaps'.

Importantly it can be clinically very difficult to identify an individual who is at risk of suicide, with a person's level of risk changing rapidly dependent upon a range of individual and social factors[25]. Consultation for this Action Plan emphasised the need to embed in clinical practice an approach that focuses on identifying and responding to a person's need for support as opposed to one that attempts to rule out risk of suicide.

This is particularly important at times of heightened risk such as transition points in and out of care, including after discharge. Evidence suggests that comprehensive, post discharge follow-up can be highly effective in reducing a person's risk of suicide[26]. Involving families and other supporters in discharge planning can also ensure that these informal networks have sufficient knowledge to be able to support the person at risk when they leave hospital.

Although training and education in appropriate risk assessment and management is important, there are also broader system and practice issues that need to be addressed. For example clinician skills and the robustness of procedures need to be supported by appropriate organisational culture and supporting infrastructure, such as adequate staffing and resources, support from senior staff and appropriate practice guidelines[27].

Research strongly suggests restricting access to lethal means continues to be important[28]. This differs across settings and includes careful scrutiny of equipment and facilities provided at hospitals and correctional centres to eliminate or reduce the potential for harm. Within clinical settings, for at-risk clients, this may extend to limiting the amount of medication a person at risk may have access to, where it is clinically appropriate to do so.

While restricting access to the lethal means of suicide is beyond the scope of most clinical practice, means restriction counselling, in which a clinician works with clients and supportive others to educate and collaboratively develop plans to limit their access is not.

Consultations also revealed that it is important that those identified at increased risk of suicide in adult correctional centres and youth detention centres are provided with appropriate therapeutic support[29].

Our focus

Our actions will focus on the need to:

- **Equip all service providers with the necessary skills and knowledge** to identify and respond in an appropriate and timely way to support people at risk of suicide, dependent on their respective roles and responsibilities.
- **Provide person-centred assessment, support, treatment and care for those at risk** that not only considers the point-in-time clinical assessment, but the life circumstances of the person needing support, including appropriate follow-up care for those who have attempted suicide.
- Continue efforts to **reduce access to the lethal means of suicide** within facilities and community infrastructure and provide support to individuals at risk to eliminate or reduce the risk of suicide.

Significant actions to support a renewed focus

- **Enhance the capacity of hospital emergency departments to identify and respond to those at risk of suicide**. Queensland Health will implement a 12 month suicide prevention project focused on enhanced training and resources to hospital emergency departments, which will be developed in close consultation with people who have survived or been bereaved by suicide. The Queensland Centre for Mental Health Learning has been engaged, in collaboration with the Clinical Skills Development Service, to develop and deliver a targeted and sustainable training program. Training will be tailored specifically for emergency department doctors, nurses and allied health staff, to recognise, assess, manage and refer people at risk of suicide (Queensland Health).
- **Implement a suicide prevention and resilience model across Queensland's Correctional Centres to provide person-centred assessment, support, treatment and care for those at risk.** The model will be implemented in 2016 and will include the establishment of a pool of specialised external psychologists that can be drawn on to work with complex cases and to build Queensland Corrective Services' capability to respond to those at risk (Department of Justice and Attorney-General).

Good Practice Spotlight

Mental Health Clinicians in Police Communications Centre

Cross sectoral collaborations and partnerships are critical to effective suicide prevention activities.

A recent partnership between the Queensland Police Service (QPS) and the Queensland Health Forensic Mental Health Service is providing better support for those contacting triple zero for police assistance. This project aims to provide consultation, liaison and support to police at the point of crisis to improve outcomes for people experiencing a mental health related concern or presenting at risk of suicide.

This can include facilitating access to appropriate mental health services, enhancing situational awareness for responders including advice on how to best engage with a person based on their presentation and history, referrals to community mental health services for vulnerable individuals who come into contact with police, as well as issues associated with suicide risk.

The most frequent types of crisis situation referred to the clinicians to date involve people with expressed suicidal ideation or self-harm behaviour. This initiative will undergo a formal evaluation recently funded by the Commission, however preliminary findings indicate that the positions have been valued by police and have had good outcomes for consumers.

Priority Area 3:

Focused support for vulnerable groups

Our purpose

To address the specific needs of groups who are experiencing higher rates, and who are at greater risk of, suicide.

Why is this important?

Some groups within Queensland experience higher rates of suicide and are at greater risk of suicide. These groups include:

- males
- people living with mental illness and disabilities
- Aboriginal and Torres Strait Islander peoples
- people living in rural and remote Queensland
- people from culturally and linguistically diverse backgrounds
- Lesbian, Gay, Bisexual, Transgender and Intersex people
- children and young people.

Many groups experiencing high suicide rates are among the most disadvantaged and marginalised communities, reflecting wider social, geographic and economic inequities[30].

While the broader priority areas of strengthening community capacity, service responsiveness and the evidence base to support reducing suicide and its impact apply to these groups, consideration needs to be given to the unique needs and circumstances of these groups.

Activities are needed to meet the needs of those at immediate risk, combined with longer term approaches that aim to address the underlying structural inequities and social disadvantage that result in this heightened risk of harm.

What works and what is needed

Although not all people in these vulnerable groups are at increased risk of harm they are more likely to experience, and be exposed to, the underlying social and environmental factors that may lead to an increased vulnerability. As such, consideration also needs to be given to the unique underlying factors that lead to increased risk among different priority groups, as this is likely to lead to more effective interventions and outcomes.

Men

Nearly three quarters of people who die by suicide in Queensland are male[31]. Recent research shows that four consistent risk factors are associated with the higher risk of suicide in Australian men. This includes disrupted or depressed mood, along with social isolation, at least one personal stressor such as unemployment or relationship break-down, and the influence of the 'tough Aussie male' stereotype which prevents men from seeking help[32]. There is a continuing need to address stigma relating to suicide and other issues to encourage men to seek help.

Public consultation also identified the need to focus on reducing the suicide rate of older men in Queensland. In 2013, suicide rates among men aged 85 or older were considerably higher than all other age groups (38.3 per 100,000)[33]. Research also indicates that the influence of certain risk factors may be different for older adults, with depression identified as a factor in around 80 per cent of suicides of this age group[34]. Those consulted indicated that there is a need for increased consideration of this higher level of suicide risk in policy and program development as well as the need for improved accessibility to mental health services for older men experiencing depression and or suicidal ideation.

People living with mental illness and disabilities

Almost one half (49.2 per cent) of people who died by suicide in Queensland between 2002 and 2011 had at least one diagnosable psychiatric disorder and one-quarter had consulted a health professional about their mental health in the three months before they suicided[35].

It is important to note that mental illness alone does not lead to suicide. People with a mental illness are, however, at increased risk of suicide immediately following discharge from in-patient care or emergency departments, especially if they have been previously suicidal, live alone, experiencing work stressors and the admission was involuntary[36]. To provide appropriate treatment and care for this cohort, consideration needs to be given to these broader life circumstances and risk factors that may lead to an increased vulnerability to suicidal behaviour.

Mental health problems and high levels of psychological distress have been associated with higher levels of suicide attempts and suicidal thoughts among people aged 16 to 64 years with severe or profound disability. The Australian Institute of Health and Welfare reports that in 2010, 42 per cent of people aged 16–64 years with severe or profound disability had seriously thought about committing suicide and around 18 per cent had attempted suicide nationally[37].

Although self-harming behaviours do not generally involve suicidal intent there is evidence to suggest that people who engage in self-harming behaviours may be at increased risk of suicide[38]. However the interventions required to reduce non-suicidal self-harm differ from those required to respond to suicide attempts as the underlying causes and motivations are different[39,40].

Aboriginal and Torres Strait Islander peoples

Suicide rates among Aboriginal and Torres Strait Islander people are 1.5 times higher than those for other Queenslanders[41]. Of further concern is that suicide rates for Aboriginal and Torres Strait Islander children aged 5 to 14 years is 10 times higher than for other Queensland children of the same age[42].

The high rates of suicide among Aboriginal and Torres Strait Islander people has been attributed to a complex interaction of factors which not only includes the disadvantage and risk factors shared by the non-Indigenous population, but also a broader set of social, economic and historic factors that specifically impact on Aboriginal and Torres Strait Islander social and emotional wellbeing and mental health[43]. It is also important to recognise the diversity of Aboriginal tradition and Torres Strait Islander customs, with numerous languages, kinships, tribes and ways of living across Queensland.

Evidence suggests that improving the social and emotional wellbeing of Aboriginal and Torres Strait Islander peoples will lay the foundation for reduced suicide rates, with the need for these initiatives to be implemented through locally developed and owned strategies.

There is a particular need to focus on Aboriginal and Torres Strait Islander children and young people given the significantly higher rates of suicides in this age cohort.

In families and communities bereaved by suicide, grief, loss and mourning may have a powerful and sustained effect, particularly when there are strong cultural and family obligations to participate in numerous funerals and grieving rituals[44]. To respond appropriately to this issue at an individual and community level, culturally appropriate and capable postvention support is needed.

Future directions in this area will be informed by findings from the current *Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project*, funded by the Australian Government, when they become available. This evaluation aims to evaluate the effectiveness of existing Aboriginal and Torres Strait Islander suicide prevention services and programs, and where relevant will make recommendations about areas of improvement, or alternative, evidence based service and program delivery models.

Rural and remote communities

Suicide rates in remote communities are almost double those in metropolitan locations. For remote areas this equates to 23.4 per 100,000, in comparison to 12.6 per 100,000 for metropolitan areas[45]. For regional areas rates are 15.7 per 100,000.

The wellbeing of people residing in rural and remote communities can be affected by a variety of social, financial and environmental factors such as limited employment or education opportunities, social and geographic isolation, economic hardship and uncertainty as well as the hardship and stress associated with extreme weather conditions. Further, a lack of information and accessible, quality services may make people residing in rural and remote areas less likely to seek, or receive, treatment or support[46].

Not all rural and remote communities are the same, with significant diversity across Queensland in relation to the challenges they face and the strengths they may have.

Recognising these differences and building upon existing strengths and community partnerships, combined with informed planning and coordinated funding, is essential to improving the collective impact of activities undertaken to address high rates of suicide in rural and remote communities.

People from culturally and linguistically diverse backgrounds

People born in countries other than Australia accounted for 25.1 per cent of recorded suicides nationally between 2001 and 2010[47]. Importantly suicide rates vary according to cultural background and can depend on the stages of settlement[48]. Suicide rates are higher among immigrants from English-speaking countries and countries from western, northern and eastern Europe as these countries generally have higher rates of suicide[49].

A number of factors lead to an increased vulnerability for people from a culturally and linguistically diverse background. For example, migration related stress may contribute to the development of suicidal behaviours as it can involve considerable changes to physical, social, cultural and economic environments[50].

For refugees and asylum seekers, these issues are complicated further by transgenerational trauma, experiences of torture and their experiences of detainment and processing in this country. As the recent *National Inquiry into Children in Immigration Detention (2014)* identified, suicide risk, self-harm and distress among children in detention, including among their parents, is very high.

Consultations with organisations that work with refugees and asylum seekers identified that because of their backgrounds or experience of trauma and torture, most of their clients will screen as high risk of suicide, and many may have attempted suicide, but they are unlikely to disclose their experiences to services they are unfamiliar with.

There are also significant structural and service barriers that affect this group from being able to access the services they need, when they need them, including restricted access to appropriate interpreters or costs associated with allied health services, particularly for those who do not have a permanent visa.

Interventions which focus on enhancing the influence of known protective factors to build resilience among children and young people has shown some promise, as has intensive case management with clients who have attempted suicide, or identified as high risk, if there is an established relationship of trust between the service provider and client.

Lesbian, Gay, Bisexual, Transgender and Intersex people (LGBTI)

Studies also indicate that Lesbian, Gay, Bisexual, Transgender and Intersex people are at greater risk of suicide and attempted suicide. For example, a study found that 35 per cent of Lesbian, Gay and Bisexual people have had suicidal thoughts in their lifetime and 13 per cent had attempted suicide[51]. In comparison, 13 per cent of heterosexuals in the study were found to have had suicidal thoughts and 3 per cent had attempted suicide.

This increased risk of poor mental health and suicidality among LGBTI people is not attributable to sexuality, sex or gender identity, but rather due to experiences of discrimination and exclusion[52]. A sense of social exclusion and isolation may also mean that they are more hesitant to seek support through mainstream services, and more likely to rely on informal peer support networks. Given this reliance on peer networks, it is important that these informal gatekeepers are equipped to be able to identify the warning signs of suicide and respond appropriately.

As well as the provision of specialist services and programs, ensuring mainstream mental health and suicide prevention initiatives are inclusive is also likely to improve help seeking among this population[53], meaning they are more likely to access the necessary support and assistance from services that are available.

Children and young people

Suicide continues to be a leading cause of death for children and young people and accounted for just over half of deaths by external (non-natural) causes among children aged 10–17 years in 2013–14[54]. Suicide was also the leading external cause of death of 15 to 17 year olds during this year.

Statistics from the Queensland Child Death Register show that an estimated 23 people under 18 died by suicide in Queensland in 2013–14 at a rate of 2.1 per 100,000[55]. Nineteen of these deaths were 15 to 17 year olds and four were 10 to 14 year olds. Recent research indicates that in Australia one in 13 young people aged between 12 and 17 years reported seriously considering suicide and one in 20 reporting a clear plan, with a very high rate of expressed suicidal ideation in teenage girls[56].

The suicide rate of children and young people between 1 July 2005 and 30 June 2013 has been relatively stable at 1.8 per 100,000. During this time there were 169 suicide deaths of children and young people aged 0 to 17 years. Of these 65 were known to the child protection system[57]. This translates to children and young people known to the child protection system being 3.9 times more likely to suicide than all young people in Queensland (7.1 suicides per 100,000 compared to 1.8 per 100,000)[58].

A child or young person becomes 'known to the child protection system' when the Department of Communities, Child Safety and Disability Services becomes aware of child safety concerns, alleged harm or alleged risk of harm or they took action under the *Child Protection Act 1999*[59].

Research has highlighted particular risk factors for suicidal behaviour in children and young people including exposure to parental domestic violence, mental health problems, and adverse family experiences[60]. For example, the higher rates of suicide among children and young people known to the child protection system is related to their living circumstances which may include a lack of attachment to families and significant others, a history of neglect, abuse or violence and exposure to parental mental illness and problematic substance use.

Flexible models of service delivery have been recognised as important in providing improved responses to children and young people at risk of suicide, including mobile outreach and extended hours of service delivery. Evidence also demonstrates the effectiveness of universal social and emotional learning programs within schools and other key settings, particularly when they are embedded within the curriculum, focused on building supportive environments and supported by targeted interventions for those who need them[61].

Our focus

Our actions will focus on strategies that aim to:

- Improve the effectiveness of mainstream services to better understand and respond to the needs and circumstances of vulnerable groups.
- In partnership with at-risk groups, customise approaches to meet their unique needs and circumstances ensuring they are included in the planning, implementation and evaluation of such initiatives.

Significant actions to support a renewed focus

- **Scope current service models, barriers for accessing services and options for improvement for Aboriginal and Torres Strait Islander young people at risk of suicide** within the Townsville region. This will particularly focus on the need for after-hours support for Aboriginal and Torres Strait Islander children and young people who are at imminent risk of harm, in consultation with local service providers and community representatives (Queensland Mental Health Commission).
- **Contribute to, and partner in, national research projects including *Improve men's access to care: a national ambulance approach to reduce suicide and to improve the mental health of men and boys*.** The Queensland Ambulance Service is a partner in a national, ambulance based $2.7 million project to reduce suicide and to improve the mental health of men and boys. The three year project is being led by Monash University, funded by the Movember Foundation, and will map the needs of men and boys through ambulance presentations, and identify key intervention points for linkage to appropriate care. A number of workforce education paramedic-delivered interventions will also be developed for trial (Queensland Ambulance Service).

Good Practice Spotlight

MATES in Construction

MATES in Construction is an industry-based community development program in the building and construction industry.

Supported by key stakeholders in the construction industry including unions and employer associations, the program builds resilience and capacity around mental health and suicide at a local level on construction sites and in work camps.

It has provided General Awareness training to over 50,000 workers and has a volunteer network of over 4,000 Connectors and ASIST workers trained to recognise and help people at risk of suicide. Volunteers are supported by field officers and case managers in responding to, and supporting individuals at risk of suicide. MATES in Construction case management services are person-centred, crafting an individual case management plan for the client and assisting these clients in brokering appropriate services. Case managers work with the clients in accessing these services but also liaising with employers and volunteers on site to ensure there is support for the client in remaining in work and in a supportive environment while accessing appropriate mental health services. MATES in Construction has been comprehensively evaluated, with findings that it has resulted in workers feeling equipped to make a difference and improving understanding on site for colleagues experiencing mental health conditions. Research has shown that for every dollar spent there is a return on the investment of $4.60 through reducing suicidal behaviour. The program was introduced in Queensland in 2007 and since then suicide rates in the Queensland construction industry have fallen by 7.8 per cent. The program now operates in Queensland, New South Wales, South Australia and Western Australia.

Priority Area 4:

A stronger more accessible evidence base

Our purpose

Building a stronger, more accessible evidence base that drives continuous improvement in research, policy and practice.

Why is this important?

To increase the effectiveness of suicide prevention activities and services, communities and individuals need to know what works, when, where, how and for whom. This can be achieved through improving the translation of research into practice and providing more accessible and useful information to drive local responses.

This also requires building upon current approaches to suicide prevention and risk reduction activities by utilising the existing evidence base and committing to robust evaluations.

Continued development of existing suicide mortality and attempt data sources sets the foundation for effective suicide prevention activity through improved identification of patterns and trends and a greater understanding of the context and circumstances of these types of events.

What works and what is needed?

The routine collation and analysis of data relating to suicide assists in the identification of patterns and trends in these types of incidents, particularly among different populations or communities. It can also be used to inform the design, implementation and evaluation of preventative strategies and risk reduction activities. This is particularly important as reports of unverified suicides in the media can cause concern to communities and families.

To enhance the utility of this type of information it is important to consider ways in which to improve the standardised routine collection of demographic data in relation to suicide attempts from across relevant agencies (i.e. rates, age, gender identity, sexuality and ethnicity).

Monitoring and reporting on suicide attempts has been identified by the National Review as a significant area for improvement and one which can support a reduction in suicide.

Where possible, it is also critical to improve the capacity of systems to support a deeper, qualitative analysis of the context and circumstances of both suicides and suicide attempts, to identify the precipitating life events and situational factors which may place people at risk, but also seek to understand future opportunities for prevention.

Further, communities need to be better equipped and informed with access to more timely and reliable data, in relation to both suicides and attempted suicides that can be used to drive local responses to areas of identified need. Other areas of focus that are needed include improved evaluation of suicide prevention activities, and a sustained focus on translating relevant research into practice.

As a recent report on the effectiveness of nationally funded suicide prevention activities found, evaluations in this area have been restricted by a general absence of quantifiable outcome measurements and, if independent evaluations had been conducted, they have a tendency to report predominantly on the achievement of project objectives as opposed to short, medium or long term outcomes[62].

Importantly, research in this area is restricted by methodological concerns, particularly a lack of randomised controlled trials and an inability to accurately measure suicide-related outcomes[63]. For example it is difficult to ascertain the impact general mental health awareness or prevention programs have on suicide-related outcomes, although they are proven to enhance individual and community resilience.

Those consulted also indicated that although there is considerable research into suicide prevention activities this is not readily accessible or easily translated to improved responses and service delivery.

It is also important to consider ways to build upon current methodologies and focus on a greater inclusion of the voices of those with a lived experience in research, whose stories can make a valuable contribution to understanding the context and circumstances of these types of events. Of considerable importance is the development of evidence that highlights the importance and value of the inclusion of lived experience voices within policy, practice, service delivery and evaluations.

Our focus

Our actions will focus on the need to:

- provide more accessible research about what works to better inform service delivery and practice
- enable timely access to accurate and relevant data to inform local responses to areas of identified need
- include the wisdom of those with a lived experience into research, policy and service development.

Significant actions to support a renewed focus

- **Develop and implement a Data and Information Sharing Network** to enhance the collection, analysis and dissemination of suicide mortality and attempt data. This work will seek to improve the timeliness, accessibility and utility of this type of data and information for service providers, community representatives and other practitioners. Recognising the significant challenges with collating information about these types of incidents, the intention is to build upon existing data collection systems such as the Queensland Suicide Register. There will also be a specified focus on improved data collection for those populations that continue to experience higher rates of suicide including Aboriginal and Torres Strait Islander peoples; Lesbian, Gay, Bisexual, Transgender and Intersex people; and people from a culturally and linguistically diverse background (Queensland Mental Health Commission).
- **Trial and evaluate a Suicide Prevention Lived Experience Speakers Bureau Train the Trainer Program** to raise awareness within communities and workplaces about suicide and to empower people to take an active role in local suicide prevention activities. The Commission has provided $19,960 to Suicide Prevention Australia to develop a network of lived experience speakers in regional communities, including conducting an evaluation. To achieve this a small group of evaluation experts will be engaged to design an appropriate evaluation tool to capture the information and data required to monitor the effectiveness and impact of the Speakers Bureau (Queensland Mental Health Commission).

Good Practice Spotlight

Queensland Suicide Register

The Australian Institute of Suicide Research and Prevention (AISRAP) maintains the Queensland Suicide Register (QSR).

The QSR contains data from suicides that have occurred in Queensland from 1990 and contains a broad range of information regarding these types of deaths including the circumstances of the death, preceding life events and psychiatric history. AISRAP conducts ongoing research based on this data and compile a tri-annual report on suicide mortality rates. The QSR contributes to improved understanding of the trends and characteristics of suicide mortality and can guide the development of appropriate suicide prevention and risk management strategies.

The interim Queensland Suicide Register (iQSR), which is maintained by AISRAP, was developed to improve the timely access to suicide data in Queensland, however this system is limited to initial information provided in the Form 1 Police Report to the Coroner. The quality of this information varies greatly, and once aggregated is limited to basic demographics such as gender, age, ethnicity and geographic region. More nuanced information regarding these deaths only becomes available when the Coroner makes their findings and relevant information is uploaded into the QSR. Although not as accurate as the QSR it provides a preliminary indicator of more recent deaths. This database currently contains suicides that have occurred between 2011–2015.

The QSR is an internationally recognised suicide mortality data collection system, with other jurisdictions implementing suicide registers based on this work. The robustness of the QSR has led to improvements in national suicide data collection by the Australian Bureau of Statistics through the introduction of a revision processes in their Causes of Death data collection process. Concerns about the underreporting of suicides in Australia, highlighted by the QSR, has also informed the establishment of the National Committee for Standardised Reporting on Suicide led by Suicide Prevention Australia, with the support of the Department of Health and Ageing.

Governance and monitoring

As part of the development of a renewed approach to suicide prevention for Queensland, and to drive continuous improvement, strong cross-sectoral governance, leadership and coordination of suicide prevention activities is needed.

Although there are a diversity of suicide prevention activities currently being undertaken across the State, greater alignment and coordination is required to maximise the collective impact of these efforts.

A Queensland Suicide Prevention Reference Group will be established to support the implementation of this Action Plan, and to provide increased leadership, oversight and coordination of suicide prevention and risk reduction activities being undertaken across the State.

This reference group will comprise of a range of government agencies, non-government organisations and other experts, including people with a lived experience.

The Queensland Advisory Group on Suicide will continue under this structure with a specific focus on enhancing the usability, and timeliness of suicide mortality and attempt data across Queensland. Representatives are the key suicide data custodians in Queensland, including the Office of the State Coroner, Queensland Health, Queensland Ambulance Service and Queensland Police Service.

The Action Plan will be in place for 18 months although actions may be implemented over a longer period.

Report and review

Implementation of the Action Plan will be monitored by the Commission with progress reported in the Strategic Plan's Annual Report due for public release each December. The first report will be publicly released in December 2015 and will include a report on the implementation of the actions outlined in this Action Plan.

The activities undertaken as part of the implementation of this Action Plan are unlikely to achieve a short-term reduction in suicide or attempted suicide rates. Reducing suicide will take time, with sustained effort at both a state and national level however it is important that progress is monitored.

The Commission will monitor and report annually on age standardised suicide rates including the suicide rates for Aboriginal and Torres Strait Islander peoples, children and young people and people living in rural and remote communities. Although it is currently not possible to accurately report on suicide rates for other vulnerable populations including LGBTI people, people with a disability and particular cultural groups, work will be undertaken to improve capacity to report on this type of information.

To ensure a process of continual improvement and to align with the Australian Government's response to the National Review, the Action Plan will be reviewed after 12 months.

The Commission will also seek feedback from individuals and organisations on new and innovative ideas about other actions that could be implemented.

Our actions

Actions outlined within this Suicide Prevention Action Plan are a mixture of new initiatives, examples of promising practice and continuing successful activities that have demonstrated effectiveness.

Priority Area 1:

Stronger community awareness and capacity

What we will do

1.	**Develop and trial a place-based suicide prevention initiative that builds on community strengths in a rural and remote community.** Queensland Mental Health Commission	This project aims to build upon existing community level suicide prevention activities, community infrastructure and strengths to enhance their responsiveness to local need. In consultation with local communities this initiative will be trialled in up to two sites in Queensland from the beginning of 2016.
2.	**Work with national partners including *beyondblue* to support a range of community awareness, education and stigma reduction activities that aim to reduce suicide risk by supporting people to enhance their mental health and improve opportunities for people to get the right help at the right time when they are unwell.** Queensland Mental Health Commission	The Queensland Mental Health Commission provides $645,000 per year to *beyondblue* as a contribution to its nation-wide services, initiatives, research partnerships and campaigns. These include resources such as *Finding your way back: A resource for people who have attempted suicide; Guiding their way back: A resource for people who are supporting someone after a suicide attempt* and *Finding our way back: A resource for Aboriginal and Torres Strait Islander peoples after a suicide attempt.* As of the end of July 2015, 19,400 copies of these resources have been provided to Queenslanders.
3.	**Increase community awareness of suicide prevention activities through enhanced coordination and promotion of community events for World Suicide Prevention Day.** Queensland Mental Health Commission	Coordinated by Suicide Prevention Australia, World Suicide Prevention Day is designed to demonstrate global commitment to suicide prevention and the Commission will work with lived experience representatives and other services to promote community led events across the state.
4.	**Review the accessibility of resources to assist and support people bereaved by suicide, as well as for people who have attempted suicide, their families, friends and other support persons.** Queensland Mental Health Commission	Although many organisations provide support to people bereaved by suicide, including through telephone support lines and on-line resources, the Commission will work with people with a lived experience to identify the availability, accessibility and utility of these supports, including those for different vulnerable population groups, people who have attempted suicide and their families, friends and support persons.
5.	**Provide resilience training for staff identified as first responders to assist them in managing the personal impact of attending to traumatic or stressful situations.** Department of Justice and Attorney-General	Participation also aims to promote access to additional supports such as the Employee Assistance Program.

What we will do

6.	**Support the MATES in Construction Scoping Project *'Saving lives in the Construction Industry'*** to identify options to expand its suicide prevention initiatives to rural and regional Queensland and to include small and medium sized businesses. Queensland Mental Health Commission	This project will examine and provide recommendations on future priorities and sustainable funding options for effective 'wrap around' services for suicide prevention and postvention in the construction industry.
7.	**Develop a Queensland Police Service framework for *Improving Mental Health, Well Being and Suicide Prevention Plan 2015-17.*** Queensland Police Service	As a prevention and postvention plan to better manage mental health issues within the Queensland Police Service, including procedures for post-incident management.
8.	**Provide programs for front line officers that focus on post-incident support including FireCare and Embrace and improved access to employee assistance programs.** Queensland Fire and Emergency Services	Deliver Peer Support Officer training on suicide and suicide awareness, to enhance the responsiveness of existing networks.
9.	**Continue facilitation of Employee Exposure Prevention and Support Programs to provide employee assistance and psychology services.** Queensland Rail	This encompasses specific initiatives for relevant operational staff such as a peer support program for Rail Traffic Crew and processes to reduce the exposure of Station Operations personnel to traumatic events such as fatalities. Pre-employment assessment measures are also included for certain roles that may be exposed to traumatic incidents.

Priority Area 2:

Improved service system responses and capacity

What we will do

10. Enhance the capacity of hospital emergency departments to identify and respond to those at risk of suicide. Queensland Health	Queensland Health will implement a 12 month suicide prevention project focused on enhanced training and resources to hospital emergency departments, which will be developed in close consultation with people who have survived or been bereaved by suicide. The Queensland Centre for Mental Health Learning has been engaged, in collaboration with the Clinical Skills Development Service, to develop and deliver a targeted and sustainable training program. Training will be tailored specifically for emergency department doctors, nurses and allied health staff, to recognise, assess, manage and refer people at risk of suicide.
11. Implement a 'Suicide Recognition and Intervention' training package for front line Queensland Rail staff. Queensland Rail	Developed in 2015 for front line staff, the training package provides an overview of suicide prevention providing factual information on mental health and stigma; identifying behavioural indicators of suicide; appropriate ways to communicate with a person who is showing signs of suicide or self-harm; immediate actions to be taken by front line staff; and tailored processes for notification and response.
12. Continue training front line PoliceLink staff in understanding suicidal behaviours and managing callers at high risk of suicide. Queensland Police Service	An evaluation of the training was undertaken in 2013 which identified that the satisfaction of call takers relating to confidence with taking such calls increased from 20 per cent to 80 per cent after training. Queensland Police Officers will continue to receive training on suicide prevention, risk reduction and other mental health related issues through First Response Officer Training, First Year Constable training, Mental Health Training and Applied Suicide Intervention Skills Training (ASIST).
13. Provide mental health training for school staff to identify individuals at risk and respond appropriately. Department of Education and Training	Including utilising school based resources such as youth support coordinators, school nurses and Indigenous community liaison officers. This work is supported by existing state-wide departmental procedures and guidelines including those that focus specifically on suicide prevention, intervention and postvention support.
14. Support improved responses in public hospitals by reviewing and updating existing education and support resources. Queensland Health	Such as the *Guidelines for Suicide Risk Assessment and Management* to include clinical best practice for emergency departments and the *Queensland Mental Illness Nursing Documents Essentials* resource to include a greater focus on suicide prevention.
15. Improve the identification and assessment of people at risk of suicide at the point of admission into custody in Queensland's Correctional Centres. Department of Justice and Attorney-General	In 2015–16 specialised skills based training will be made accessible for staff completing front line risk assessments and will supplement available mandatory online training modules.
16. Require Senior Guidance Officers and Guidance Officers, as first responders in State Schools, to attend suicide prevention and intervention training. Department of Education and Training	Training is currently offered to Senior Guidance Officers, Guidance Officers and school leaders but is not mandatory.
17. Provide training, support and resources to assist staff, as well as foster and kinship carers, to understand and respond to the mental health needs of children and young people. Department of Communities, Child Safety and Disability Services	This is supported by existing policies and procedures that are designed to assist staff to effectively assess and respond to suicide risk and self-harm, as well as a foster and kinship carer support line to assist carers in managing a range of issues, including when young people in their care are at risk of self-harm or suicide.

What we will do

18. Implement a suicide prevention and resilience model across Queensland's Correctional Centres to provide person-centred assessment, support, treatment and care for those at risk. Department of Justice and Attorney-General	The model will be implemented in 2016 and will include the establishment of a pool of specialised external psychologists that can be drawn on to work with complex cases and to build Queensland Corrective Services' capability to respond to those at risk.
19. Enhance personal resilience of prisoners and strengthen protective factors through the delivery of the Strong Not Tough Adult Resilience program. Department of Justice and Attorney-General	The Strong Not Tough Adult Resilience program will be rolled out in 2015–16 to assist prisoners build emotional and social skills, and resilience strategies that are both practical and useful for coping with stressful circumstances. The initial target group will include prisoners with a history of suicidal ideation or experiencing adjustment difficulties within the correctional environment.
20. Pilot a project to deliver best practice support and follow-up care to people who have attempted suicide, or expressed significant suicidal ideation. Queensland Mental Health Commission	The project will consider ways to better support people who have attempted suicide or expressed significant suicidal ideation in the community and through health and other services. It will seek to improve linkages between hospitals and community sectors and appropriately engage families and other support persons in follow-up care.
21. Continue to ensure that young people in youth detention centres are in a safe environment where risk of, and opportunity for, suicide and self-harm is minimised. Department of Justice and Attorney-General	This includes ensuring operational staff are annually trained and/or assessed to manage suicide risk and respond appropriately, and that specialised multi-disciplinary teams are available to assess, manage and work intensively with young people at risk of suicide or self-harm.
22. Implement updated *Operational Practice Guidelines for Probation and Parole* for managing offenders under community based orders identified as at increased risk of suicide. Department of Justice and Attorney-General	This includes appropriate risk mitigation strategies based on the level of identified risk.
23. Continue risk assessment of all people in custody in police watchhouses, with appropriate management of those at high risk. Queensland Police Service	This will prevent the likelihood of a person committing suicide or self-harming, through routine monitoring and reducing access to the lethal means of suicide.
24. Continue to expand safer cell measures in Queensland's correctional centres. Department of Justice and Attorney-General	All new prison cells constructed since 1996 have been designed to minimise suicide by hanging. Refurbishments to pre-existing cells have increased hanging point reduction measures to 92 per cent of all built cells. An audit of international best practice in relation to safer cell design will also be undertaken.
25. Develop an environmental safety guideline that is designed to promote a culture of safety and the necessary system supports in acute mental health inpatient wards. Queensland Health	The guideline will provide information for managers, educators, clinicians and other staff on available resources and actions to assist in preventing, responding to and learning from patient safety incidents.

Priority Area 3:

Focused support for vulnerable groups

What we will do

26. Contribute to, and partner in, national research projects including *Improve men's access to care: a national ambulance approach to reduce suicide and to improve the mental health of men and boys*. Queensland Ambulance Service	The Queensland Ambulance Service is a partner in a national, ambulance based $2.7 million project to reduce suicide and to improve the mental health of men and boys. The three year project is being led by Monash University, funded by the Movember Foundation, and will map the needs of men and boys through ambulance presentations, and identify key intervention points for linkage to appropriate care. A number of workforce education paramedic-delivered interventions will be also be developed for trial.
27. Provide staff education and support to improve awareness to better respond to people presenting at risk of suicide in regional locations or at customer service counters, and implement internal workforce awareness strategies through existing Health and Wellbeing programs. Department of Natural Resources and Mines	The Department of Natural Resources and Mines provides support and information to those living in communities. Providing front line staff with education to increase awareness of suicide prevention will enable them to respond more effectively to those who may be at risk of suicide.
28. Continue to support the Drought Wellbeing Service to increase access to community based, clinical mental health services in drought affected areas. Queensland Health	Queensland Health will provide $1.5 million in 2015–16 to continue existing Drought Assistance measures including continued funding for the delivery of the Royal Flying Doctors Service Drought Wellbeing Service.
29. Reform the youth justice system to ensure it is more responsive to issues impacting on young people's offending behaviour with an improved focus on mental health needs. Department Justice and Attorney-General	This will involve a focus on evidence based responses to young people's mental health needs including the delivery of timely assessment and coordinated interventions by youth justice and partner agencies. In 2015–16, youth justice will examine the application of trauma informed care with the intent of initially trialling this way of working with young people in detention before rolling it out across the State in future years. Youth detention centres will also continue to provide 24 hour onsite medical facilities staffed by a Clinical Nurse and mental health professionals who work with the multi-disciplinary team to provide therapeutic support to young people.
30. Improve outcomes for children in contact with the child protection system. Department of Communities, Child Safety and Disability Services	This will involve a review of therapeutic services available to young people in care and implementing the Child and Family Reform Program that aims to reduce child abuse by supporting families earlier, to keep children safe and provide for their wellbeing.

What we will do

31. Implement the new *Strengthening Families Protecting Children Framework for Practice* which will provide child protection practitioners with a common set of values, knowledge and practice tools. Department of Communities, Child Safety and Disability Services	This will assist workers to engage with children and young people to build therapeutic relationships focused on increasing children and young people's safety, belonging and wellbeing (including emotional and mental health wellbeing).
32. Scope current service models, barriers for accessing services and options for improvement, for Aboriginal and Torres Strait Islander young people at risk of suicide within the Townsville region. Queensland Mental Health Commission	This will particularly focus on the need for after-hours support for Aboriginal and Torres Strait Islander children and young people who are at imminent risk of harm, in consultation with local service providers and community representatives.
33. Develop tailored suicide prevention training and materials to support culturally and linguistically diverse communities, particularly communities from a refugee background, to recognise and support a person who is at risk of suicide. Queensland Mental Health Commission	In partnership with community representatives, this work will commence in 2016 and will tailor existing suicide awareness training and initiatives to meet the needs of people from culturally and linguistically diverse backgrounds. It will aim to empower community members to identify and support a person at risk of suicide.

Priority Area 4:

A stronger more accessible evidence base

What we will do

34. Support innovative research that aims to better identify and respond to the unique risk and protective factors that may lead to groups or populations being at increased risk of harm. Department of Justice and Attorney-General	This includes the ongoing evaluation of intervention programs such as the Strong Not Tough Adult Resilience program and the Real Understanding of Self Help (RUSH) program being undertaken by Queensland Corrective Services and research into the increased risk of suicide among farming communities being supported by the Commission and the Office of the State Coroner.
35. Develop and implement a Data and Information Sharing Network to enhance the collection, analysis and dissemination of suicide mortality and attempt data. Queensland Mental Health Commission	This includes developing an approach that builds upon existing data collection systems such as the Queensland Suicide Register. This work will seek to improve the timeliness, accessibility and utility of this type of data and information for service providers, community representatives and other practitioners. There will also be a specified focus on improved data collection for those populations that continue to experience higher rates of suicide including Aboriginal and Torres Strait Islander peoples; Lesbian, Gay, Bisexual, Transgender and Intersex people; and people from a culturally and linguistically diverse background.
36. Maintain the Child Death Register, which includes details of all child deaths including suicides since 2004 and report on data and trends annually. Queensland Family and Child Commission	The Queensland Family and Child Commission makes data available to genuine researchers to support research on risk factors associated with child deaths and the development of prevention strategies.
37. Partner with other jurisdictions to develop a national surveillance system for overdose and suicidal behaviour. Queensland Ambulance Service	The aim of this project is to use national ambulance data to develop, pilot and implement a population level acute mental health case monitoring system that records ambulance presentations for self-harm, suicidal ideation, suicidal intent and attempts. The project was funded by the Department of Health and Ageing, led by Turning Point Alcohol and Drug Centre (Victoria), and the Queensland Ambulance has provided data to this national surveillance project to enable development of a state-based data collection system for detailed epidemiological analysis and research activities.
38. Monitor and analyse suicide and self-harm incidents in order to support security operational tasking across the south east Queensland rail network in both the short and mid-terms. Queensland Rail and Queensland Police Service	The analysis includes strategies to allow the early detection of high risk individuals on the network and aims to ensure that escalating behaviours are identified more effectively for recidivist individuals presenting on the network.

What we will do

39. Review the deaths and serious injuries of children who were known to Child Safety within one year prior to the incident or who were in out-of-home care at the time of the event, including suicides. Department of Communities, Child Safety and Disability Services.	Child Death Review Panels will conduct a review when a child or young person in care has died by suicide. The purpose of the review is to facilitate ongoing learning and foster improvement in the provision of services and accountability within Child Safety Services. Outcomes of the review will help inform whether appropriate case management and service delivery responses were provided to assist the young person.
40. Implement a process for monitoring and analysing incidents of suspected suicide and significant self-harm involving individuals with current or recent contact with a Queensland Health service. Queensland Health	This project will extend upon existing mortality review processes within Hospital and Health Services across the state and will inform strategic directions, policy and clinical practice, with a view to improving the care of people presenting at risk of suicide.
41. Undertake systematic monitoring of suicide and self-harm incidents including a regular review of Queensland Corrective Services suicide and self-harm data. Department of Justice and Attorney-General	Identify trends and areas requiring additional resources and/or strategies and inform future practice and staff training. This includes a review of current capability to provide timely access to data to correctional centres and district offices to inform local responses to suicide risk.
42. Trial and evaluate a *Suicide Prevention Lived Experience Speakers Bureau Train the Trainer Program* to raise awareness within communities and workplaces about suicide and to empower people to take an active role in local suicide prevention activities. Queensland Mental Health Commission	The Commission has provided $19,960 to Suicide Prevention Australia to develop a network of lived experience speakers in regional communities, including conducting an evaluation to monitor the effectiveness and impact of the Speakers Bureau.

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Interpreter

Translation

The Queensland Government is committed to providing accessible services to Queenslanders from all culturally and linguistically diverse backgrounds. If you have difficulty in understanding the Action Plan, you can contact us on **1300 855 945** and we will arrange an interpreter to effectively communicate the report to you.

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