June 2015

SUICIDE PREVENTION IN QUEENSLAND: CONTINUING THE CONVERSATION

Discussion paper

Purpose

This discussion paper seeks to continue the conversation with Queenslanders about a renewed approach to suicide prevention.

It outlines the themes arising from consultations held to date and evidence about what works to reduce suicide and its impact on Queenslanders. It also outlines the proposed goal and priority areas for a *Queensland Suicide Prevention Action Plan* (Figure 1).

The Action Plan

Queensland has committed to developing and implementing a renewed approach to suicide prevention through the *Queensland Mental Health, Drug and Alcohol Strategic Plan 2014-19*. The Queensland Mental Health Commission is leading this work and is developing a whole-of-government *Queensland Suicide Prevention Action Plan*.

The Action Plan will focus on those actions specifically aimed at reducing suicide and its impact on Queenslanders. It will include examples of established programs that have been shown to be effective, promising initiatives, and those focused on achieving systemic change.

The Commission will be working over the next few months with partner agencies to coordinate or realign existing resources, and explore opportunities for supporting promising practice or initiatives that aim to reduce suicide across Queensland.

Other Action Plans will set the foundation for reduced suicide by addressing broader mental health and wellbeing including the Mental Health Awareness, Prevention and Early Intervention and the Alcohol and other Drugs action plans.

The Action Plan will be in place for 18 months although actions may be implemented over a longer period. To ensure continual improvement the Action Plan will be reviewed by the Commission after 12 months. This will again involve consultation with government agencies, non-government agencies, the Queensland Mental Health and Drug Advisory Council and the broader community including people who have been affected by suicide.

The Commission plans to publicly release the Action Plan in September 2015.

The Action Plan will be developed based on data about suicide and attempted suicide rates across the State; research into what works to reduce suicide and its impact including evaluations of services and initiatives; and themes arising from consultation processes led by the Commission. It also has regard to the changing policy and funding environment which effect suicide prevention activities.

SEEK HELP

National 24/7 Crisis Services

- Lifeline 13 11 14
- Suicide Call Back Service 1300 659 467
- MensLine Australia 1300 78 99 78

National Support Services

General support

- beyondblue support service 1300 22 4636 or email or 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

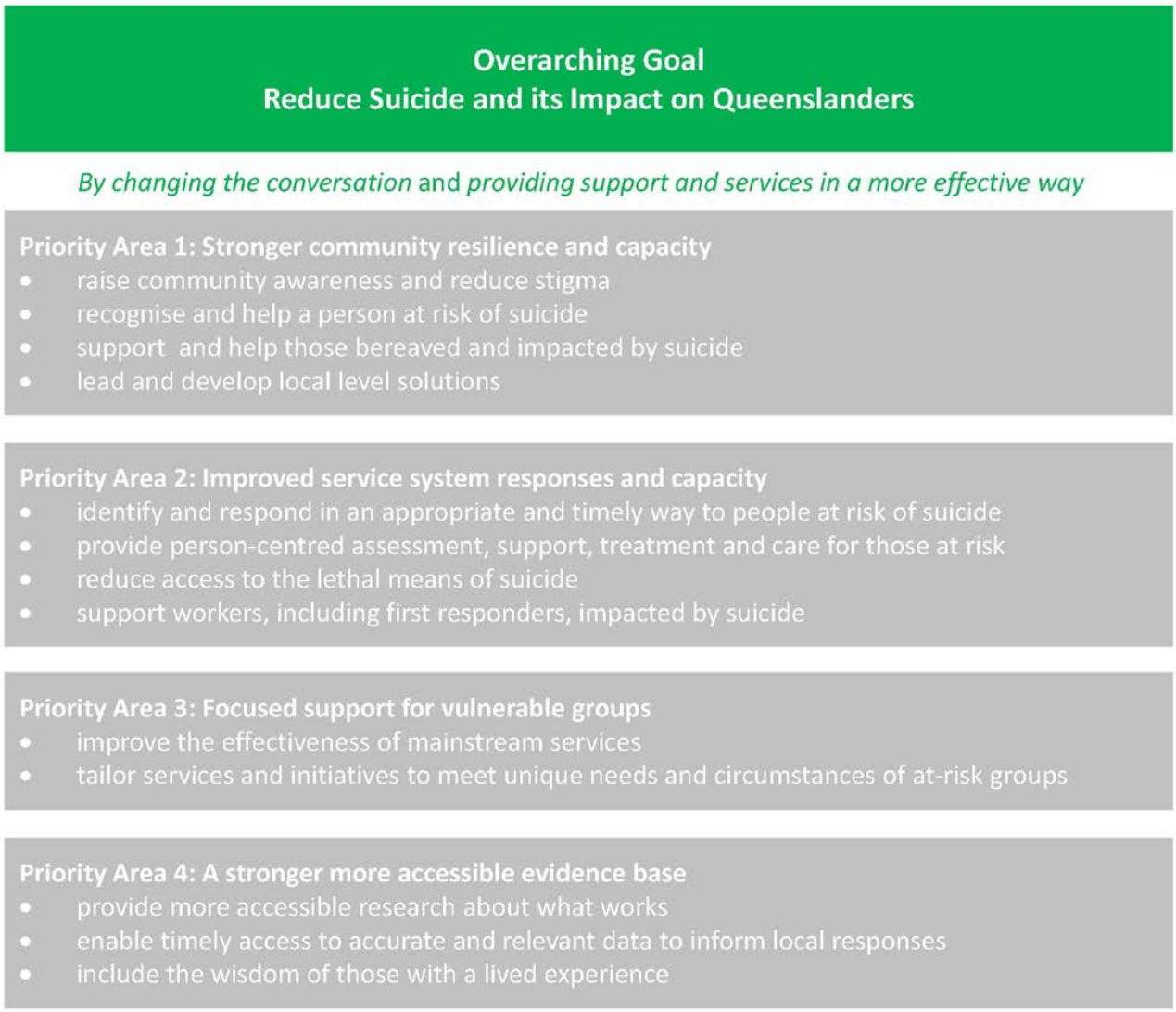

Figure 1 – Goal and priority areas of the Queensland Suicide Prevention Action Plan

Share your views and experiences

Stakeholders, community representatives and other interested parties are invited to consider the questions outlined below and provide feedback. Feedback will inform the development of the final Action Plan.

We are seeking your views and experiences in relation to the following:

1. Does the Action Plan's proposed goal support a renewed approach to suicide prevention in Queensland?
2. Are the proposed Priority Actions for the Action Plan likely to make a difference?
3. What actions do you believe should be taken to reduce suicide and its impact on Queenslanders?
4. What is currently being done that works or could be improved?
5. Any other views you would like to share?

Feedback can be sent to suicideprevention@qmhc.qld.gov.au by **Friday, 31 July 2015.**

Background

What is the impact of suicide in Queensland?

In Queensland 627 people took their lives in 2014[1]. For every person who dies by suicide, an estimated 30 people attempt suicide[2].

While suicide rates have been relatively stable in Queensland at around 13.3 per 100,000 people between 2009-2013, they continue to be higher than the 10.9 per 100,000 national rate (Figure 2). Nearly three quarters of all people who die by suicide are male, with the highest suicide rates occurring in the most disadvantaged and marginalised communities, reflecting wider social, geographic and economic inequalities[3].

The effects of these tragic events are immediate, far-reaching and long-lasting. They are felt by families, friends, work colleagues, first responders and the broader community.

The number of people who are bereaved by suicide is difficult to quantify. One study indicates that for every suicide, six people identify as being bereaved by suicide. They include parents, spouses, children and siblings. The response of people bereaved by suicide is made all the more challenging due to their attempts to make meaning of the death, guilt, blame, isolation, complicated grief and they experience slower recovery[4].

There are also significant impacts on service providers, particularly those providing support and treatment and first responders including police, ambulance and emergency services.

These effects of suicide translate to an economic cost. A conservative estimate of the national economic cost of suicide and suicidal behaviour is $17.5 billion every year[5] which includes the years of life lost, lost productivity including among survivors, and the cost to services.

What factors influence suicide and suicide attempts?

There is no single factor that contributes to suicide or suicide attempts, and it is best understood as a complex interaction between a variety of risk factors and a lack of protective factors across a person's life span.

There are known risk factors that place some people, at certain times in their lives, at greater risk. Some risk factors are situational and include loss of a job, relationship breakdown or intoxication. Other factors can have a cumulative effect over time. They may include childhood trauma or abuse, family environment, and personality characteristics.

A common misconception is that all people who suicide or attempt suicide have or are experiencing a mental illness or a mental health problem. Although there is a strong relationship between the two, it is influenced by a range of other risk and protective factors. To reduce suicide and its impact we also need to focus on other issues which may increase risk of suicide amongst different populations or cohorts.

State/Territory	Males	Females	Persons
New South Wales	13.8	4.6	9.1
Victoria	14.5	4.5	9.4
Queensland	**20.7**	**6.2**	**13.3**
South Australia	18.6	5.5	11.9
Western Australia	20.5	6.5	13.4
Tasmania	21.1	7.4	14.0
Northern Territory	27.9	6.2	17.6
Australian Capital Territory	13.9	4.4	9.1
National	**16.7**	**5.2**	**10.9**

Figure 2 – Suicides by state and territory between 2009-13 (Age Standardised Rate per 100,000)

Source: Australian Bureau of Statistics Causes of Death report (2014)

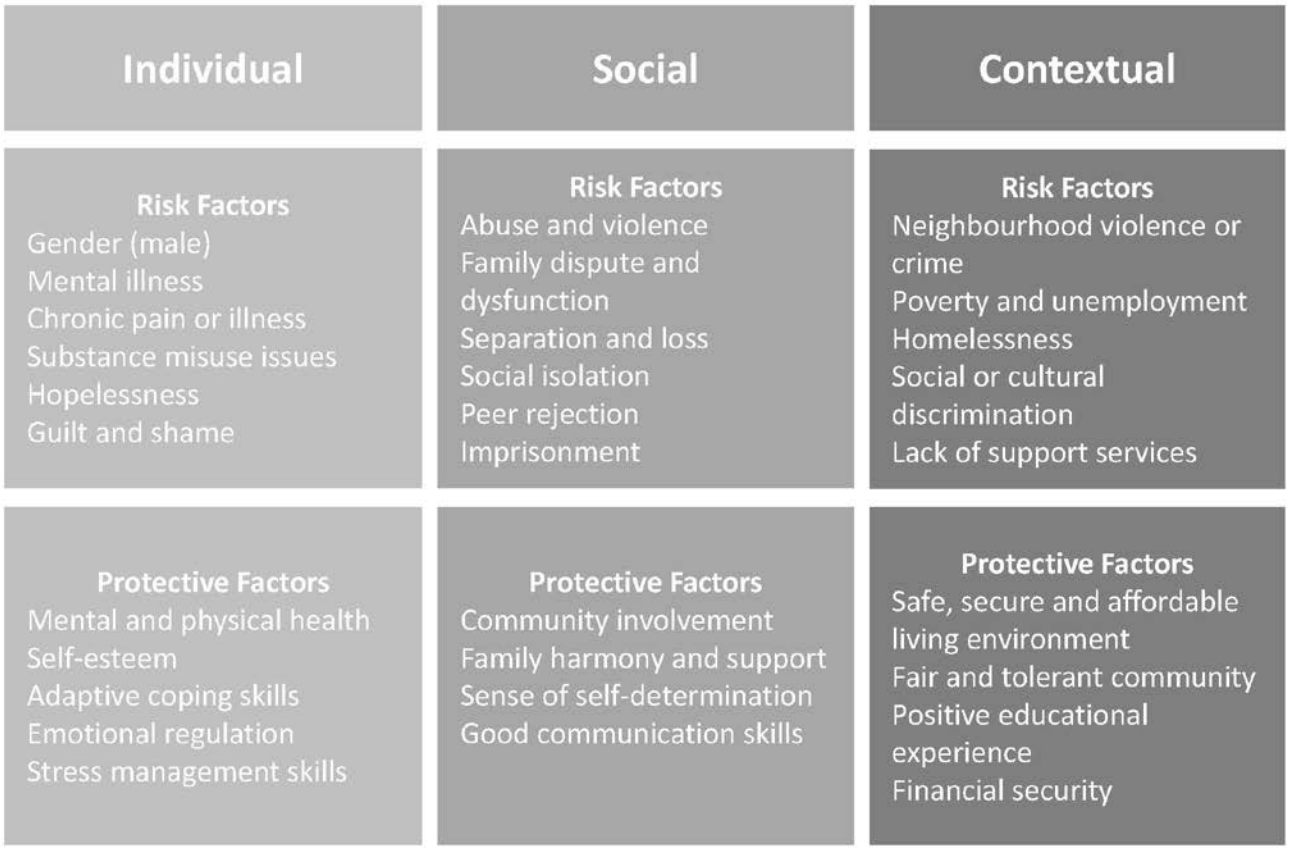

Figure 3 – Risk and Protective Factors at the Individual, Social and Contextual Levels[6]

Risk factors alone do not determine whether a person will engage in suicidal behaviour. Protective factors also influence a person's actions. These factors enhance an individual's resilience and capacity to cope with life stresses[7]. These include such factors as coping skills[8], social attachments and connections and a sense of purpose. The influence of risk and protective factors may differ according to a person's age, cultural background or geographical location[9].

What can be done to prevent and reduce suicide and its impact?

Given the range of factors that influence suicide and suicidal behaviours, it is essential that a broad approach which involves strengthening protective factors and reducing the influence of risk factors is taken.

As outlined in Figure 3, risk and protective factors interact at the individual, social and contextual level. These factors can be influenced through targeted action. For example, a sense of social connectedness can be enhanced by actions that will enhance the quality of and access to social support and networks, and inclusion and participation.

Suicide and suicide risk are reduced through activities across three interrelated areas of focus:

- **Prevention** activities include public education, community awareness or training programs, including those that focus on improving awareness of the warning signs of suicide, or improved help seeking, as well as addressing the social determinants of mental health and wellbeing through intersectoral collaborations (i.e. housing, education and employment)
- **Intervention** activities 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 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.

Each of these occur:

- at the *population level* which may include actions to build supportive and inclusive communities, reduce

access to lethal means of suicide, reduce the harmful use of alcohol, responsible reporting by the media, and improving public awareness.

- through *targeted interventions* for specific settings or vulnerable groups through, for example, gatekeeper training for front line workers in primary care, schools, emergency services, prisons and health facilities.
- at an *individual level* effective approaches seek to enhance the management and continued care of people who have attempted suicide and the assessment and management of people at possible imminent risk. This includes training of general practitioners in brief cognitive behavioural therapies, ensuring high quality treatment for people experiencing mental illness, and appropriate and continuing care for people discharged from inpatient care and emergency departments.

At all levels, actions need to be tailored to meet the needs of specific groups and individuals.

As outlined in Figure 3, best practice approaches to suicide prevention reflect a continuum of activities across eight areas, from prevention, treatment through to continuing care for those at immediate risk of harm.

FIRST DO NO HARM

Underpinning all strategies regardless of their type or level is the principle of *'first do no harm'* with the need for continual awareness of the potential for unintended consequences for individuals, families and supporters and the community.

What is currently being done?

Across Queensland there are a large number of existing suicide prevention programs, services and initiatives which occur across the continuum of prevention, treatment and care activities (Figure 4).

Many are funded by the Australian and State Governments while others draw support from community and private sector contributions. Significant contributions are also made by services not directly focused on suicide prevention including housing, education and employment and local government services that address broader social and contextual factors affecting suicide risk amongst different individuals or populations.

The Australian Government plays a significant role in suicide prevention, providing funding and in some cases directly delivering services and initiatives that seek to reduce suicide particularly for vulnerable groups. For example, the *National Suicide Prevention Programme* (NSPP) funds suicide prevention activities across the Australian population and for specific at-risk groups including men, Aboriginal and Torres Strait Islander peoples, people living in rural and remote communities, people bereaved by suicide, people with a mental illness and young people. The NSPP also contributes funding to other Commonwealth-funded mental health programs, including *Access to Allied Psychological Services* (ATAPS) and *MindMatters*, for the inclusion of suicide prevention specific activities under these initiatives.

One of the key findings of the National Mental Health Commission's *National Review of Mental Health Programmes and Services 2014* (the National Review) is that many of these services are not integrated and that there continues to be significant barriers to access for those seeking help.

What are the future directions for reducing suicide?

Any action taken by the State Government should complement rather than duplicate Australian Government funded services. There is also a need for improved service integration across sectors to ensure a seamless person-centred approach to supporting people at high risk of suicide.

The recent *National Review* examined Australian Government suicide prevention initiatives and services. It considered a range of factors including efficiency and cost-effectiveness, duplication in current services and programs, gaps in services and programs as well as specific challenges for Aboriginal and Torres Strait Islander people and regional, rural and remote Australia.

The final report has been provided to the Australian Government and while they are yet to provide a response to the Review, there are a number of significant findings relevant to the development of this Action Plan, including:

- when there is limited or no follow up and support after a suicide attempt, there is a missed opportunity to prevent future attempts, reduce suicides and save lives, particularly following discharge
- there is a need to focus on systemic, multi-level and cross-sectoral community based approaches to suicide prevention as evidence indicates that they

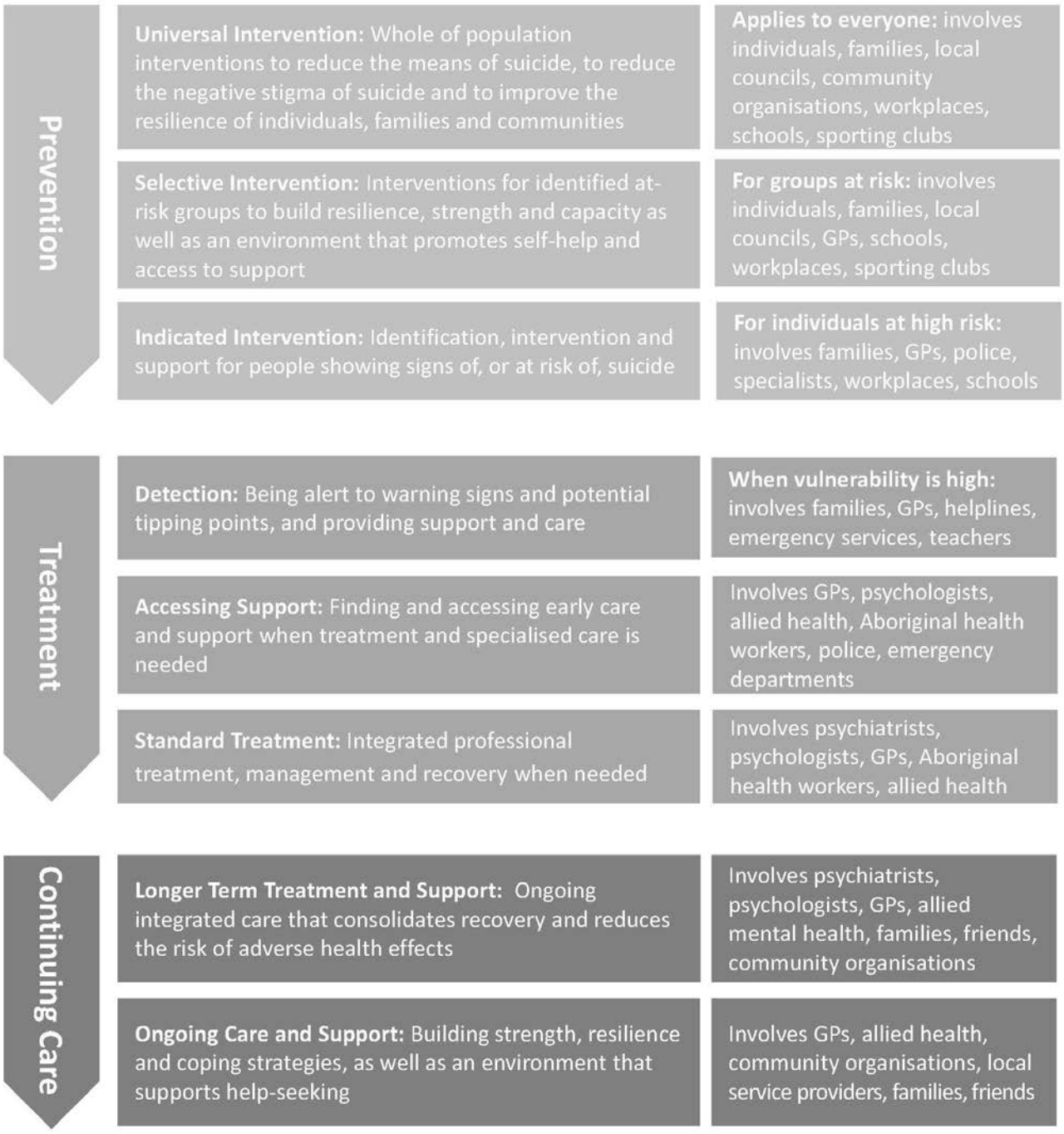

Figure 4 – Continuum of Best Practice Suicide Prevention Activities as outlined in the LIFE framework[10]

are the most likely to be effective at reducing suicide rates

- there is a need to focus on improving the quality of service responses to people who seek help for suicidal ideation or attempts, and those who are trying to assist them, including adopting a *'no wrong door approach'*
- this should also include ensuring first responders and health professionals who are likely to come into contact with people at risk are appropriately trained in communication and other relevant skills.

These findings align with issues identified during the development of the Action Plan and will be taken into account. The Commission notes the significant recommendations made by the National Mental Health Commission, for example building workforce and research capacity to support systems change, the need for a national framework and the establishment of 12 regions across Australia as the first wave of a nationwide introduction of sustainable, comprehensive, whole-of-community approaches to suicide prevention (recommendation 19).

If implemented these recommendations have the potential to significant change the way suicide prevention initiatives and services are delivered and coordinated.

Extending the scope of Primary Health Networks as the key regional architecture for equitable planning, and purchasing of mental health programs, services and integrated care pathways (recommendation 8) is also likely to lead to improved access to appropriate care for those persons presenting at-risk of suicide.

While the Australian Government resolves these issues it is important that actions continue to be taken in Queensland to reduce suicide and its impact.

What we have heard so far

To identify the Action Plan's priorities and directions the Commission hosted three Strategic Conversations in March and April 2015. The Commission has also undertaken a range of targeted consultations, including with people who have a lived experience of suicide.

Key themes emerged including 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 among families, peers and the community
- enhance the availability, suitability and accessibility of service for people at risk
- better use available suicide data and information to more effectively inform community and service responses
- increase practical guidance about what initiatives work, when, where and for whom.

Stakeholders strongly indicated that although there is a diversity of suicide prevention initiatives currently being undertaken across the State, greater alignment and coordination is required to avoid duplication in areas while major gaps exist in other areas of need.

To be effective coordination is required at all points of planning and implementation.

Action Plan Priority Areas

Based on this evidence and the outcomes of consultations to date, four priority areas are proposed for the Action Plan. Outlined below is the evidence that will guide actions taken under the priority areas.

PRIORITY AREA 1: Stronger community resilience and capacity

The places where we live, learn, socialise and work all have a critical role to play in the prevention of suicide. This includes providing social support and connectedness, meaningful activities, detection and support of vulnerable individuals, addressing stigma, engaging in follow-up care, and supporting those bereaved by suicide[11].

Building capacity within our key environments is likely to reduce suicide rates, by encouraging dialogue around suicide, reducing social isolation, and improving access to acute services.

Within communities there is also the potential to address the broader social determinants of suicide, through targeting risk and protective factors that occur at a social or contextual level.

Raising community awareness and reducing stigma

Responding to someone who is having suicidal thoughts or is at risk of suicide can be difficult particularly where issues relating to stigma prevent that person from seeking help when they need it[12]. This includes stigma associated with suicide, but also with those conditions that contribute to suicide risk, such as financial hardship, relationship breakdowns, homelessness and mental illness[13].

Reducing stigma through improving our understanding of these issues may enhance disclosure and help-seeking, and help ensure they access timely support and assistance when they need it.

It is important to recognise that as well as stigma there are other factors that impact on a person seeking help, for example having negative experiences of services when help was previously sought may stop someone from accessing that type of support again.

It is also vitally important that there are appropriate services and support available when and where a person needs them.

Recognising and helping a person at risk of suicide

Those consulted by the Commission indicated that many people and communities lack the knowledge and confidence to recognise, and safely respond to, a person who may be at higher risk of suicide.

Although many people at risk show warning signs such as withdrawing from friends and family or a sense of hopelessness, they may not openly initiate a discussion about suicide. Equipping individuals, families, peers and communities with the skills and capacity to be able to recognise and assist a person at risk of suicide, their families and support persons, including those bereaved by suicide, is an important way to ensure more people get the help they need, when they need it.

The conversations that people have about suicide differ depending on different situations, for example whether they are responding to a person who may be at immediate risk of harm, or supporting someone who is bereaved by suicide.

Service example

There are many government, non-government and community organisations that are contributing to better awareness and reducing stigma. This includes through the provision of training in evidence based programs such as *ASIST*, *Conversations for Life* and *Mental Health First Aid Training*.

The Queensland Government contributes funding to *beyondblue* to support a range of community awareness, education and stigma reduction activities. As a national initiative, *beyondblue* works to reduce the impact of anxiety, depression and suicide in the community by raising awareness and understanding, empowering people to seek help and supporting recovery, management and resilience. This includes online resources to provide information and links to other organisations for people bereaved by suicide, those concerned about a friend or family member, or anyone who may be suicidal.

What we want to see

A needs-based and coordinated approach to equipping all Queenslanders with the knowledge and skills to recognise and assist a person at risk of suicide, their families and support persons.

Other factors such as cultural background, age and relation to the person at risk also changes the nature and type of conversations. A number of resources such as *Conversations Matter*[14] and *Conversations for Life*[15] exist that provide guidance in relation to having safe conversations about suicide including the importance of addressing myths associated with suicide and to not unintentionally normalise suicidal behaviour.

It is important to note 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[16].

There have been significant improvements in this area with the development of media guidelines[17] and the national *Mindframe* initiative which aims to provide access to current, evidence-based information to support the appropriate reporting, portrayal and communication about suicide and mental illness.

Providing support to communities, families and people impacted by suicide

It is important to be aware of, and appropriately manage, the impact of a suicide among families and friends and within communities. Being bereaved by suicide may lead to an increased risk of suicide, particularly for individuals or communities that are already vulnerable.

This type of support also aims to prevent contagion of suicidal behaviour amongst vulnerable individuals or communities, and reduce the potential of a suicidal cluster occurring[18].

Improving access to an integrated service system that meets local needs and circumstances

All communities have different resources and needs that may change over time, particularly those areas that experience natural disasters and droughts. What works in a city, with an established, large and accessible service network may not be effective in a small regional town, with limited local services, that may be open for a day or two a week or located in a neighbouring town.

As well as actions that support and increase social capital and access to resources, ensuring that services complement each other and work together to maximise their collective impact is important. This includes working with services that do not have a specific suicide

prevention role, but address known contributing factors such as those that build resilience or social connectedness.

PRIORITY AREA 2: Improved service system responses and capacity

The 'service system' is made up of a wide variety of services and agencies. It includes those services that people at risk of suicide may come in contact with including hospital, health, doctors, schools, Centrelink, child protection, justice and other social support services.

Identifying and responding to people at risk of suicide

These services play a vital role in suicide prevention through addressing many of the underlying risk factors associated with suicide and suicidal behaviour. They are also in a unique position to identify those at risk and respond in a timely manner.

To undertake this role, health and service providers need to be supported with the necessary skills and knowledge to identify and respond to a person at risk of suicide. 'Gatekeeper' training is one of the most effective ways that this can be achieved.

Studies indicate that these workers may not feel confident or equipped to deal with people at risk of suicide due to inadequate training[19] and there is a need for all professionals who come into contact with people at risk of suicide should undergo suicide intervention training, regularly[20].

Many agencies also have their own suicide risk assessment guidelines and protocols for responding to people at risk of suicide relevant to the circumstance or field they work in (i.e. schools, Corrective Services and Child Safety Services). These types of guidelines are an important element in ensuring a sustained focus on, and response to, suicide risk in the community or amongst different population groups.

The usual practice in responding to someone at immediate risk of harm is for a referral to mental health services and general practitioners and in case of crisis, emergency departments, for assessment, care and treatment.

Accessing and providing continuous care, support and treatment

Accessing appropriate assessment, care, support and treatment for those experiencing suicidal ideation or who have attempted suicide is essential to preventing suicide. As noted by the National Mental Health Commission's *National Review* suicide attempts are one of the main predictors of subsequent attempts, and or, later suicide deaths.

However for those people experiencing a crisis, which may not always be mental illness related, finding and accessing appropriate support can be very difficult. In these situations people at risk may not meet clinical criteria for inclusion to a mental health service, and as a result end up 'falling through the gap'.

To effectively respond to those at risk of suicide there is a need to adopt a person-centred approach which considers not only the point in time clinical assessment but considers the circumstances of the person needing support.

This is particularly important at the point of hospital discharge which represents a time of heightened risk. Transitions in and out of care are known risk times and evidence suggests that post discharge follow up is highly effective in reducing a person's risk of suicide[21]. Involving families and other supporters in discharge planning can ensure that they have sufficient knowledge and are equipped to support the person at risk when they leave hospital.

Studies also indicate a need to address barriers to people at risk of suicide accessing hospital care. These include inadequate staffing and resources, lack of support from senior staff and a lack of guidelines[22]. A 2014 study highlighted factors that affect the responsiveness of emergency departments to caring for patients who deliberately self-poisoned. Key themes from the study highlighted that emergency department staff believed they lacked the skills and confidence to effectively manage these patients. The study concluded that there is a need to provide emergency department staff with specialist support, knowledge, skills and guidelines to provide effective care[23].

Clinician skills and the robustness of procedures need to be supported by appropriate organisational culture and supporting infrastructure.

Reducing access to lethal means

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]. Research highlights the effectiveness of restricting access to the lethal means of suicide, particularly where the method is regularly used, highly lethal, prevalent and not easily substituted such as firearms, pesticides and toxic gas[25].

As the recent *Inquest into the Death in Custody of Farrin John Vetters* highlighted, restricting access to a ready means of suicide is a critical component of any suicide prevention strategy, with careful scrutiny of equipment and facilities provided at institutions to eliminate or reduce the potential for harm[27].

Hanging is the most frequently used suicide method in Queensland, with recent studies showing its increased use for both men and women[28]. Significant efforts have been made in Queensland to reduce 'hanging points' in prisons and youth detention centres. Work does need to continue not only in watch houses and correctional centres, but in other settings as well.

The principle outlined by the Coroner's Court also applies in other settings. Within clinical settings, with at-risk clients, this may also extend to consideration of 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.

It is important to note that while there remains a strong perception that in the absence of their chosen means of suicide, people will switch to another option, this is not always the case as people tend to not substitute with another method[29].

Service example

The *Hospital and Health Services Suicide Risk Assessment and Management Project* (HHS SRAMP) is a key suicide prevention activity undertaken by the Queensland Government since 2010. Funding is provided to deploy dedicated clinical positions located within acute care mental health teams in hospital and health services[26] to improve the detection, assessment and appropriate management of people at risk of suicide.

These positions aim to enhance the quality and timeliness of suicide risk assessment and management across the public health service system, including emergency departments through quality improvement, educational, clinical and collaborative activities. An independent evaluation is being undertaken of this program which will be used to inform future directions for suicide risk detection and management in public health settings across Queensland.

In early June 2015, the Minister for Health and Minister for Ambulance Services also announced that emergency department staff in Queensland public hospitals will receive training to recognise, assess and manage people at risk of suicide.

What we want to see

A responsive service system, where people can access and receive the support they need, when and where they need it, and which can respond effectively and holistically to a range of presenting issues, whether they are psychiatric, social, medical, financial or interpersonal.

Supporting first responders and other service providers

In recent years there has been an increasing focus on the impact of suicide on service providers, particularly first responders. As the 2010 Senate Inquiry *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 were resulting in vicarious trauma, causing stress-related anxiety, depression and post-traumatic stress disorders[30].

Consultations with government agencies over the past 12 months have indicated that stigma plays a significant role in workers, particularly police, accessing support when they need assistance in managing the personal impact of being required to respond to these types of events.

PRIORITY AREA 3: Focused support for vulnerable groups

Certain populations experience higher rates of suicide including 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 or children and young people experiencing family disruption or who are in contact with the child protection system.

While the broader priority areas of strengthening community capacity, service responsiveness and the evidence base are just as relevant for different priority groups, consideration needs to be given to the specific ways in which this is translated for each cohort, community or workforce.

Strategies are needed to address the needs of those at immediate risk, combined with longer term strategies to address the underlying structural inequalities and social disadvantage that result in this heightened risk of harm. To be effective and sustainable at-risk populations need to be engaged and involved in the planning, implementation and evaluation of initiatives that are designed to reduce the prevalence of suicide and suicidal behaviour among these high risk groups.

Aboriginal and Torres Strait Islander peoples

Suicide is significantly more frequent in Aboriginal and Torres Strait Islander communities, with rates that are 50 per cent higher than those of other Queenslanders[31].

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 impact on Aboriginal and Torres Strait Islander social and emotional wellbeing and mental health[32].

Family and community recovery from bereavement through suicide is complicated by the traumatic nature of these types of deaths, stigma and the frequency of this cause of death for Aboriginal people[33]. In families and communities which are highly interconnected this 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[34].

To appropriately respond to this issue, expertise in postvention support within communities and Aboriginal and Torres Strait Islander organisations is needed.

Evidence suggests that improving the social and emotional wellbeing of Aboriginal and Torres Strait Islander peoples will lay the foundation for reduced suicide rates.

Other programs that have been effective in reducing suicide include those developed and run by communities for example the *Yarrabah Family Life Promotion Program* which was in place in the late 1990s and was evaluated based on comparisons with other communities.

Some non-Indigenous specific services have also been shown to be effective such as *Mental Health First Aid Training* if they are adapted to meet the unique cultural needs of Aboriginal and Torres Strait Islander peoples and communities.

The Australian Government has recently funded an *Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project* scheduled for completion in August 2015. This project aims to evaluate relevant suicide prevention services and programs, identify Aboriginal and Torres Strait Islander suicide prevention needs and identify system level change in this area.

People who live in rural and remote communities

Preliminary 2013 data from the Queensland Suicide Register suggests suicide mortality was two times higher in remote areas and 28 per cent higher in regional areas compared to metropolitan areas[35]. Research led by the AISRAP has shown that suicide among agricultural workers in Queensland is 2.1 times higher than for agricultural workers in New South Wales[36].

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.

Greater recognition of the potential stressors associated with residing and working in remote areas is required. For example in comparison to urban locations, relationship conflict, alcohol use disorder as well as income and work problems were more significant in rural localities[37].

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 in address high rates of suicide in rural and remote communities.

Lesbian, gay, bisexual, transgender and intersex people

Due to limitations in data and methodology, it is difficult to ascertain the rate of suicide amongst lesbian, gay, bisexual, transgender and intersex (LGBTI) people as it is may not have been identified in police or coronial reports.

Service example

The Queensland *Ed-LinQ Initiative*[38] aims to improve linkages between the education, primary care and mental health sectors to enhance the early detection and collaborative management of mental health difficulties and disorders affecting school-aged children and young people. This encompasses strategies to improve referral pathways to appropriate services for a range of mental health related issues including suicidal ideation.

A recent independent evaluation of the *Ed-LinQ* program confirmed many positive aspects, with benefits for schools, health and mental health services and partnerships. The Commission is currently working with stakeholders from across the health, education and community sector to plan how to build on the achievements of the *Ed-LinQ* Initiative and address the areas identified for improvement.

What we want to see

Improved effectiveness of mainstream services, and tailored services and initiatives to meet unique needs and circumstances of at-risk groups.

What is evident is that LGBTI people experience higher rates of psychological distress, with significantly more having experienced suicidal thoughts or attempted suicide than the heterosexual population[39].

This increased risk of mental ill health and suicidality among LGBTI people is not attributable to sexuality, sex or gender identity, but rather due to experiences of discrimination and exclusion[40]. 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, meaning they are more likely to access the necessary support and assistance.

Focusing on those who have attempted suicide

While it is difficult to predict whether people will suicide, evidence suggests that one of the best predictors are previous attempts. Focusing on people who have attempted suicide presents an opportunity to reduce suicide and its impact.

This includes ensuring appropriate support and continuing care is provided to people who have attempted suicide, or seek assistance for suicidal ideation, as well as their family, friends or other support persons.

It also includes our capacity to adequately capture this information in our data collection systems and to explore opportunities for linking data across services to obtain a more detailed understanding of the context and circumstances of these types of incidents over the life-course.

A deeper analysis of these records may also yield valuable information regarding their experiences with emergency services and the public health system.

Life stages and circumstances

People can be at higher risk of suicide at certain stages of their lives, with children and young people being especially vulnerable particularly if they are known to the child protection system or have a stressed or dysfunctional family background. This includes exposure to neglect,

abuse, domestic and family violence or parental mental health and/or substance misuse issues[41].

In 2012–13 suicide was the leading external (non-natural) cause of death for children aged 10–14 years with the highest rate of suicide for this age group recorded since 2004 (4.1 deaths per 100,000 children aged 10–14 years). Suicide was the second leading external cause of death for young people aged 15–17 years (5.5 deaths per 100,000 young people aged 15–17 years).

In total, suicide accounted for 46.8 per cent of deaths by external causes among children and young people aged 10–17 years in 2012–13[42].

Certain life circumstances can also increase a person's risk of suicide, which emphasises the need for a broad cross-sectoral response to this issue. For example in a recent report from the Queensland Suicide Register of suicides that occurred in Queensland between 2002-11, relationship problems and or conflict was the most frequently recorded life event of people who died by suicide, followed by financial problems, recent bereavement, pending legal matters, recent or pending unemployment or other work and school related problems[43]. Almost half of all people who died by suicide had at least one diagnosed psychiatric disorder[44].

Suicide is also the leading cause of death in women within 42 days after their pregnancy and between 43 and 365 days following birth[45]. There appears to be a significant worldwide risk of maternal suicide following termination of pregnancy[46].

Other groups requiring effective suicide prevention efforts include people recently released from prison, people recently bereaved or divorced, refugees, and elderly people.

PRIORITY AREA 4: Strengthening the evidence base

One of the main issues raised by those consulted is that while there is a significant body of research regarding suicidal behaviour and prevention activities there are areas that require further development including:

- improved accessibility of relevant research to inform service delivery and practice
- data that is provided in timely manner to inform local action
- research that includes the views of those with a lived experience.

Practice example

The Commission funds the Australian Institute of Suicide Research and Prevention (AISRAP) to maintain the *Queensland Suicide Register* (QSR). The QSR contains data from suicides that have occurred in Queensland from 1990-2012 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 conduct ongoing research based on this data and compiles a tri-annual report on suicide mortality rates.

The QSR is an internationally recognised suicide mortality data collection system. However there is a need for continued development to expand its capability and ensure greater alignment between differing research, policy and practice needs.

The Commission is currently considering ways in which to improve the standardised and routine collation of data in relation to suicide attempts, across different agencies to improve responses.

What do we want to see?

Timely, accessible and useful data on suicide and suicide attempts, that can be used to inform policy and practice responses across Queensland communities.

Research to inform effective services and practice

As the *2013 National Report Card on Mental Health and Suicide Prevention*[47] highlights, there is a substantial lack of robust evidence in relation to effective suicide prevention services and strategies.

Evaluations of the effectiveness of nationally funded suicide prevention activities have been restricted by a general absence of quantifiable outcome measurements and, if independent evaluations had been conducted, they tend to report predominantly on the achievement of project objectives as opposed to short, medium or long term outcomes[48].

Research in this area is further restricted by methodological concerns, particularly a lack of randomized controlled trials and an inability to accurately measure suicide-related outcomes[49]. 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.

This highlights a need to incorporate evaluation in program and service design which is outcome focused, as opposed to activity based.

There are few evaluations of Indigenous-specific suicide prevention programs in Australia. A number of effective non-Indigenous-specific programs have been shown to be culturally appropriate and acceptable to Indigenous people[50].

There is also a need to make research and evaluation findings available to service providers and communities.

One of the most significant gaps in the evidence base identified by stakeholders consulted by the Commission and in the National Commission's review, is the voice of those with a lived experience. It is essential that these experiences inform future actions and are included in research and evaluation activities.

Timely access to accurate and relevant data

The routine collation and analysis of injury and mortality data assists in the identification of patterns and trends particularly among different populations or cohorts. It can also be used to inform the design, implementation and evaluation of preventative strategies and risk reduction activities.

To enhance the utility of this type of information it is important to consider ways in which to enhance the standardised routine collection of demographic data (i.e. rates, age, gender, ethnicity). But it is also critical to, where possible, improve the capacity of systems to support a deeper, qualitative analysis of the context and circumstances of these types of incidents, precipitating life events and situational factors which place people at risk.

One of the issues identified during consultations held by the Commission was the need for communities to have timely access to data, particularly suicide attempt data, to inform local responses.

Further information

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