Clinical Excellence Division

Suicide Prevention Health Taskforce

Phase 1 Action Plan
November 2016

Queensland Government

Suicide Prevention Health Taskforce — Phase 1 Action Plan

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Context

Suicide prevention is a high priority for the Queensland Government.

The Queensland Suicide Prevention Action Plan 2015–2017 was developed by the Queensland Mental Health Commission as a whole-of-government, whole-of-community plan aimed at reducing suicide and its impact on Queenslanders through actions under four priority areas:

1. Stronger community awareness and capacity
2. Improved service system responses and capacity
3. Focused support for vulnerable groups
4. A stronger more accessible evidence base.

The Queensland Suicide Prevention Action Plan 2015–2017 emphasises the importance of a comprehensive cross-sectoral approach to suicide prevention. Within this context, Hospital and Health Services and Primary Health Networks play an important leadership role in partnering with other local service providers and people with a lived experience to improve the health system's capacity to respond to people at risk of suicide. The delivery of quality, timely, and appropriate suicide risk assessment, management and ongoing care is a vital component to a comprehensive cross-sectoral approach to suicide prevention.[1]

Data from January to June 2015, indicates that almost 25 per cent of people who died by suspected suicide had contact with a Queensland Health service within the seven days prior to their death. Whilst it is unknown what proportion of these people had recent contact with a General Practitioner (GP) or other primary health care provider, research has identified that up to 45 per cent of individuals who died by suicide saw their GP within one month prior to death, and up to 20 per cent within one week before death.[2,3]

To help drive improvements across the health system, $9.6 million over three years has been allocated through the Suicide Prevention in Health Services Initiative (the Initiative). The Initiative forms an integral part of the plan for Queensland's state-funded mental health, alcohol and other drug services – Connecting care to recovery 2016–2021, and comprises of three major components:

1. The establishment and operation over three years of a Queensland Suicide Prevention Health Taskforce as a partnership between the Department of Health, Hospital and Health Services and Primary Health Networks.
2. Analysis of events relating to deaths by suspected suicide of people that had a recent contact with a health service to inform future actions and improvements in service responses.
3. Continued implementation of training for hospital emergency department staff and other frontline acute mental health care staff in recognising, responding to and providing care to people presenting to Hospital and Health Services with suicide risk.

Effective suicide prevention requires a comprehensive multi-sectoral approach.

Hospital and Health Services and Primary Health Networks play an important leadership role in improving health service system responses and capacity.

Suicide in Queensland: A snapshot

Many individuals at risk of suicide are, in principle, identifiable and their deaths preventable.

Health services are well placed to recognise and intervene with suicidal persons.

Preliminary data, released by the Australian Bureau of Statistics showed there were 746 Queenslanders who died by suicide in 2015. This compares to 648 in 2014.

By contrast, there were 279 deaths from transport accidents in Queensland in 2015.[4]

Between 2011 and 2015 the average suicide rate in Queensland was 14.1 per 100,000. In comparison the national average was 11.5 per 100,000.[4]

Between 2011 and 2013 males died by suicide three times more often than females.[5]

There is no single factor that contributes to suicide, suicidal ideation or suicide attempts. Rather, suicidal behaviour is best understood as a complex interaction of a range of protective and risk factors.

The highest suicide rates for males were observed in those aged 35-44 years (32.59 per 100,000 and the 75+ age-group (32.33 per 100,000).[5]

The highest suicide rates for females were observed in those aged 35-44 years (11.7 per 100,000) and the 45-54 age-group (9.15 per 100,000).[5]

On a per population basis, rural and remote areas often have greater suicide rates than urban areas.

For each person who dies by suicide, an estimated 20 people attempt suicide.[6]

Suicide rates within the Aboriginal and Torres Strait Islander population, across the lifespan, are higher than other Australians. Between 2011 and 2013 the age-standardised rate in Aboriginal and Torres Strait Islander persons was 1.7 times that of other Queenslanders.[5]

While the suicide rate is higher in males than females, females attempt suicide more often.[7]

The impacts of suicide are immediate, far-reaching and long-lasting. They are felt by families, friends, work colleagues and the broader community.

Although suicide in children is considered rare it is disproportionate in relation to all deaths in this age group. Recently released ABS data showed that 31 children aged 5-14 years died by suicide in Queensland in the five years between 2011 and 2015. This corresponds to a Queensland child suicide rate of 1.0 per 100,000.[4]

Suicide Prevention Health Taskforce

The Suicide Prevention Health Taskforce (the Taskforce) was established in August 2016 to focus on the development of suicide prevention policy, strategies, services, and programs to be used in a health service delivery context in order to contribute to a measureable reduction in suicide and its impact on Queenslanders.

The Taskforce will fund initiatives based on the best available evidence and where empirical evidence is absent, or lacking, will obtain and articulate 'good practice' advice based on clinical and lived experience. All initiatives will be evaluated in order to add to the suicide prevention evidence base.

Identifying and leading innovative partnerships between Hospital and Health Services, Primary Health Networks and people with a lived experience to promote the delivery of high quality, evidence-based treatments for people identified with suicide risk is a key Taskforce objective.

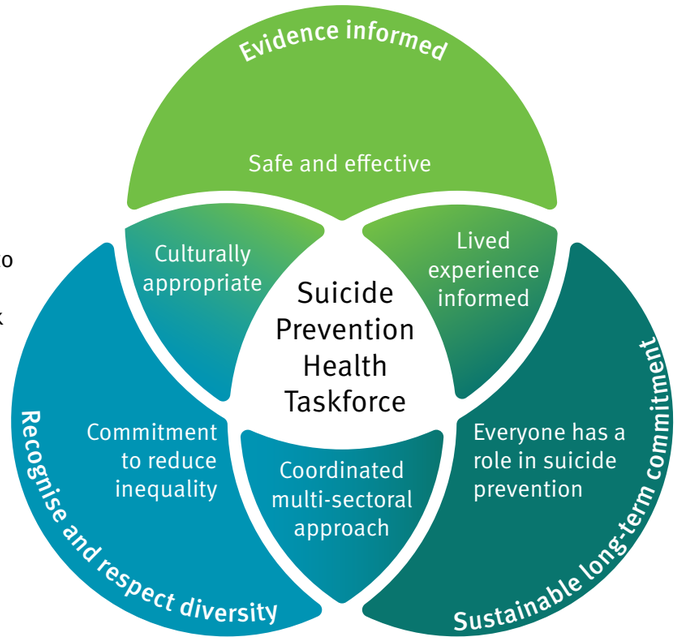
Activities falling outside the scope of the Taskforce may fall within the remit of other agencies represented on the Queensland Suicide Prevention Reference Group established to support the implementation of the Queensland Suicide Prevention Action Plan 2015–2017.

The Reference Group, supported by the Queensland Mental Health Commission exists to provide increased leadership, oversight and coordination of suicide prevention and risk reduction activities being undertaken across the State; identify opportunities to improve and inform the Queensland Government's response to suicide prevention activities; and identify future directions for suicide prevention and suicide risk reduction activities in Queensland from 2017. Membership consists of representatives from Queensland Government and non-government agencies (including four Taskforce members).

New initiatives, examples of promising practice and other activities that have demonstrated effectiveness but are outside a health service delivery context will be communicated to members of the Queensland Suicide Prevention Reference Group as required.

> A critical attribute to the successful implementation of suicide prevention strategies is organisational leadership which articulates and instils the fundamental tenet that suicide is preventable; thereby, creating a culture that considers a suicide attempt or death an unacceptable outcome of care.

Figure 1: Suicide Prevention Health Taskforce agreed principles for action



Priorities for Taskforce action

On 8 September 2016 the Suicide Prevention Health Taskforce held a Roundtable to bring together the collective expertise of a broad range of stakeholders across government, industry, and the community, and particularly those people with a lived experience, in order to inform the key priority areas for Taskforce investment. Key themes that emerged from the Roundtable included:

- Enduring cultural and systemic issues which may impact and/or hinder suicide prevention efforts.
- The importance of identifying and translating the evidence base, supporting innovation, and ensuring a commitment to robust and embedded evaluation.
- The importance of coherent, connected and consistent treatment and care
- Identifying gaps and improving linkages between hospitals and community-based services and appropriately engaging families and other support persons in the treatment and care of individuals at risk of suicide.
- Ensuring that Taskforce considerations and actions are continually informed by lived experience including that which is culturally specific.

A discussion paper considered by Taskforce members to inform the development of this Action Plan synthesized the agreed principles for Taskforce action (see Figure 1), evidence from the literature outlined on pages 11 to 14, and the abovementioned themes identified by Roundtable attendees.

The Taskforce identified three priority areas for action which were supported by the Honourable Cameron Dick MP, Minister for Health and Minister for Ambulance Services during his opening address at the Suicide Prevention Health Roundtable.

1. Skills development and support
2. Evidence based treatment and care
3. Pathways to care within and outside specialist mental health services.

Specific initiatives for Taskforce investment were further informed by engaging cultural expertise through an Aboriginal and Torres Strait Islander workshop. A mechanism for ongoing meaningful and comprehensive guidance from Aboriginal and Torres Strait Islander community members is currently under consideration. This will be guided by the Aboriginal and Torres Strait Islander Taskforce members and will ensure that cultural integrity is maintained through cultural governance and continuous feedback on all initiatives that the Taskforce has committed to.

Taskforce initiatives will be delivered in two phases. The program logic underpinning Phase 1 is outlined on pages 8 to 10. The planning and delivery of Phase 1 initiatives will commence in 2016–17. Phase 2 initiatives require further consideration and will be implemented throughout 2017–18 and 2018–19. These initiatives are outlined on page 15.

The Taskforce acknowledges that there are a number of existing exemplar programs and activities occurring within the health system and the broader social service system. The discussion paper considered by Taskforce members to inform the development of this Action Plan included information regarding the existing initiatives identified to date as described in Appendix A.

> "*Knowing is not enough; we must apply.*
>
> *Willing is not enough; we must do.*"
>
> - Goethe 1833

Program logic for Phase 1

Suicide remains a major public health problem and one of the leading

Taskforce initiatives

causes of death in Queensland.

In 2015, approximately 25 per cent of people who died by suspected suicide had contact with a Queensland Health service within the seven days prior to their death. Further, research has identified that up to 20 per cent of people who died by suicide saw their GP within one week before their death.

The Taskforce intends to address specific, tangible issues, amenable to change in a health service delivery context in order to ensure safe, accessible, integrated care is availabe to all individuals at risk of suicide and in turn contribute to a measureable reduction in suicide and its impact on Queenslanders.

Inputs		Anticipated outputs	Aspirational goals		
Lead	Action areas		Short-term	Intermediate	Long-term
Enhance the attitude knowledge, skills and resources of primary mental health care providers to			**appropriately recognise, respond to and refer people experiencing a suicidal crisis**		
Taskforce members	General Practitioner (GP) attitudes, knowledge and skill development (Action area 1)	Strategic communication with relevant peak bodies regarding Taskforce recommendation of greater inclusion and representation of lived experience within education programs targeted at GPs Strategic communication with relevant peak bodies and practicing GPs regarding identification of GP development and support needs	Increased involvement of individuals with a lived experience of suicide in GP education programs Identification of GP's development and support needs	Increased empathy and reduction in stigma Enhanced recognition, response and referral of people presenting with a suicial crisis or considered at risk	Reduction in repeated attempts and suicides
Partners in Prevention team	First responders attitudes, knowledge and skill development (Action area 2)	Education and development needs analysis of first responders - ambulance and police - with repect to responding in suicide crisis situations Education and training for Queensland Ambulance Service (QAS) and Queensland Police Service (QPS) staff	QAS and QPS officers receive education and training in suicide risk recognition, response and referral appropriate to their needs	Increased empathy and reduction in stigma Enhanced recognition, response and referral of people presenting with a suicial crisis or considered at risk	Reduction in repeated attempts and suicides
School based healthworkers	School based 'healthworkers' attitudes, knowledge and skill development needs (Action area 3)	Scope of practice review and needs analysis of support required for school based 'gatekeepers'	Identification of school based 'gatekeepers' development and support needs	Earlier recognition of risk Enhanced capacity to appropriately respond and refer	Reduction in repeated attempts and suicides
Enhance the attitudes, knowledge, skills and resources of specialist mental health providers to			**comprehensively assess and appropriately respond to a person experiencing a suicidal crisis**		
Public mental health services	Establishment of a locally identified collaborative group. Including service leaders, lived exerience representatives, primary care providers and emergency department representives Provision of training in a range of evidence-based interventions for suicide including safety planning, restriction of access to means and medication safety (Action area 5)	Development and implementation of a coherent, connected and consistent evidence-based suicide prevention pathway within specialist public mental health services	Best practise management of presentations for suicidal behaviour	Reduction in admissions, longer community tenure, increased discharge rates Improved treatment adherence	Reduction in repeated attempts and suicides

Inputs		Anticipated outputs	Aspirational goals		
Lead	Action areas		Short-term	Intermediate	Long-term
Enhance consistent treatment of suicidal behaviour by specialist mental health services using high quality, evidence based treatments					
Public mental health services	Development of an implementation plan to increase the delivery of and access to, evidence-based interventions that directly target suicidal behaviour (e.g. CBT) Development and implementation of an evaluation strategy to measure the effectiveness of implemented actions (Action area 5)	Development and implementation of a coherent, connected and consistent evidence-based suicide prevention pathway within specialist public mental health services	Best practise management of presentations for suicidal behaviour	Reduction in admissions, longer community tenure, increased discharge rates Improved treatment adherence	Reduction in repeated attempts and suicides
Enhance appropriate continuing care options following an acute crisis					
HealthPathways team	HealthPathways (Action area 8)	Review and strengthen HealthPathways to incorporate professional and patient resources relating to suicide risk	GPs will have increased access to relevant professionals and patient resources relating to suicide risk recognition and pathways to care	Enhanced recognition, response and referral of people presenting with a suicial crisis or considered at risk	Reduction in repeated attempts and suicides
New initiative	Lived experience peer support (Action area 6)	Development and evaluation of lived experience peer support approaches (including Aboriginal and Torres Strait Islander peer support)	A clearly articulated model for lived experience peer support	Availabillity of lived experience peer support as a therapeutic option	Reduction in repeated attempts and suicides
Partners in Prevention team	Enhancing first responses to suicidal crisis situations (Action area 2)	QAS access to mental health clinical advice Identification of appropriate care pathways for people experiencing suicidal crisis	Increased mental health clinical support to QAS and QPS officers involved in a suicidal crisis Increased use of appropriate referral pathways by QAS and QPS	Enhanced recognition, response and referral of people presenting with a suicial crisis or considered at risk by QAS and QPS	Reduction in repeated attempts and suicides
Strengthen the cultural capacity and capability of public mental health providers					
Queensland Centre for Mental Health Learning	Cultural appropriateness of Suicide Risk Assessment and Management in Emergency Departments (SRAM-ED) (Action area 4)	Video resources depiciting a culturally appropriate assessment of an Indigenous person for use in the simulation training component of SRAM-ED	Strengthening of cultural appropriateness of SRAM-ED	Increased cultural capability and capacity of staff	Reduction in repeated attempts and suicides
Enhance the provision of support for carers in order to reduce caregiver burden					
New initiative	Carer support (Action area 7)	Development of a model of care for people who care for someone who has attempted suicide	A clearly articulated model of care for people who care for people with issues related to suicide	Improved responses to the specific needs of individuals who care for people with issues related to suicide in order to reduce caregiver burden	Reduction in repeated attempts and suicides

Rationale behind Taskforce initiatives

To effectively reduce suicide and its impact a multi-level, multi-component, systems-based approach is required. The Black Dog Institute and the NHMRC Centre of Research Excellence in Suicide Prevention (CRESP) have developed an integrated systems approach to suicide prevention. Derived from contemporary empirical evidence, the systems approach consists of nine strategies.

Predictions of impact for each of the nine strategies shown in Figure 2 have been calculated by research at the NHMRC Centre for Research Excellence in Suicide Prevention (CRESP)[8] and are shown in Figure 3 and 4.

Figure 2: The nine strategies that make up the systems-approach to suicide prevention

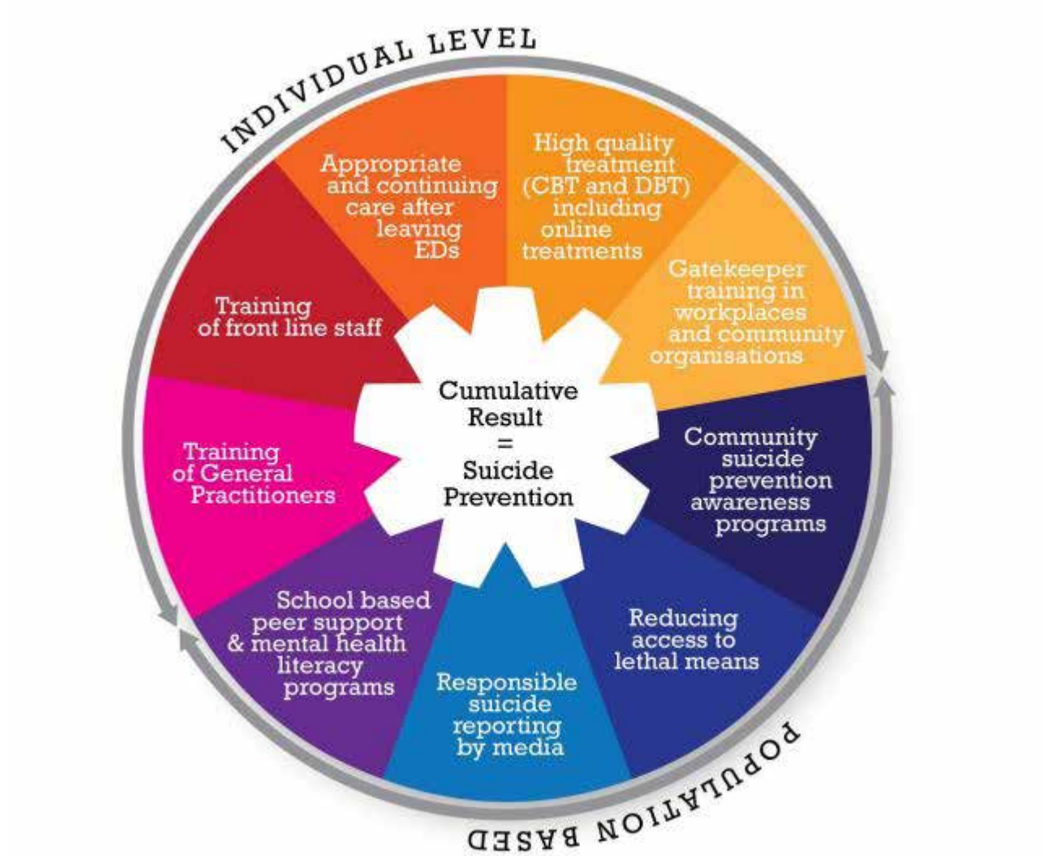
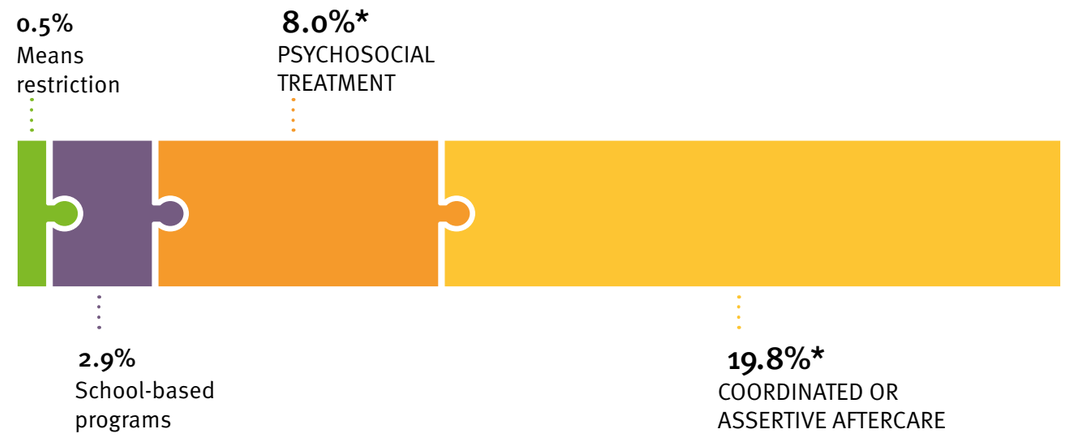
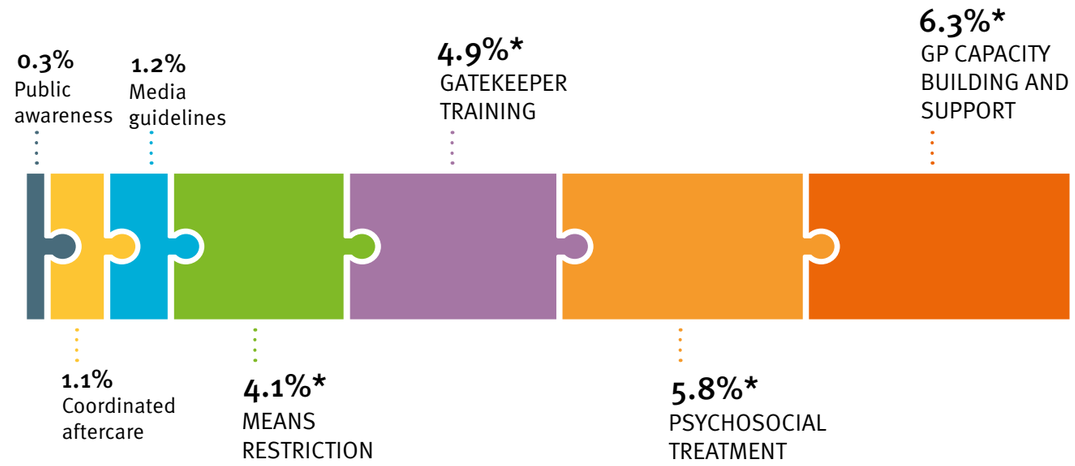


Figure 3: Estimated reduction in suicide attempts for certain strategies



*priority strategies for reducing suicide attempts

Figure 4: Estimated reduction in suicide deaths for certain strategies



*priority strategies for reducing suicide deaths

Figures 1-3 images source: Ridani, R., Torok, M., Shand, F., Holland, C., Murray, S., Borrowdale, K., Sheedy, M., Crowe, J., Cockayne, N., Christensen, H. (2016). An evidence-based systems approach to suicide prevention: guidance on planning, commissioning, and monitoring. Sydney: Black Dog Institute

Priority area one: Skills development and support

Why is this important?

- Regular suicide prevention training for front line staff (including ambulance) and GPs are core features of an integrated systems-approach to suicide prevention (Black Dog Institute and CRESP).
- Strong themes emerge from both literature sources and anecdotal evidence that there are varying levels of competence and confidence amongst medical, nursing and allied health clinicians.[9,10]
- Improving GP recognition of depression and suicide risk evaluation is one of the most promising interventions towards a reduction of suicide.[1]
- GP capacity building is one of the most promising suicide prevention strategies.[1]
- Preliminary consultation has revealed divergent views on the needs of GPs in Queensland and applicability of existing training to meet these needs.
- Ambulance officers are a pivotal point of contact to engage individuals that require mental health intervention.[11] An analysis of emergency calls to the Queensland Ambulance Service (QAS) in 2015 identified that over 38,000 calls were attributed to mental health related emergency situations. 73% of these calls were associated with self-harm or suicidal behaviours.
- However, emergency officers may receive only limited training in relation to responding to individuals with mental illness.[12]
- There is no uniform national approach to suicide prevention at a tertiary education level. Overall, knowledge and attitudes related to suicide prevention are taught more comprehensively than are skills[13]. The age of this study is acknowledged here however anecdotal evidence indicates few changes in current tertiary curriculum content.
- Improving the education and training of tertiary students is a complex task due to the independence of and variety of educational institutions. There is a need for suicide prevention training early in the education and training of health related professionals.[14]
- In addition to knowledge-ability, attitudes towards suicide influence an individual's ability to effectively recognise and appropriately intervene with suicidal behaviour. As such, training needs to also incorporate reducing stigmatising attitudes and beliefs toward suicide and suicidal individuals.
- Research on Australian ED nurses found that attitudes towards individuals presenting with self-inflicted injuries were influenced by their perceptions of their ability to effectively respond.[15] Studies have shown that staff attitudes toward suicidal behaviour are mixed.

Good practice spotlight

Suicide Risk Assessment and Management in Emergency Departments (SRAM-ED)

The Queensland Centre for Mental Health Learning, in conjunction with the Clinical Skills Development Service, has developed and delivered a training package using a train-the-trainer model, tailored specifically for ED doctors, nurses and allied health staff, to recognise, assess and appropriately manage people at risk of suicide. Suicide Prevention in Health Services Initiative funding of $620K over three years will support the ongoing implementation of this training program.

Priority area two: Evidence based treatment and care

Why is this important?

- Research shows that treatment helps people recover from suicidal thoughts or feelings.[16,17]
- Treatment of people at risk of suicide must address all factors identified in the comprehensive assessment of the individual. Treatment planning should be directed at mitigating the risk factors and strengthening the protective factors that are modifiable.
- Interventions should be evidence based and consider the person's needs, wishes and resources.
- While not all people who die by suicide have a mental illness, a mental illness may heighten a person's risk for suicide. Treating psychiatric disorders is a central component of suicide prevention.
- Suicide risk needs to be addressed directly, rather than only as a symptom of an underlying mental health condition. Research suggests that targeting and treating suicidal ideation and behaviour independently of co-existing diagnoses hold the greatest promise for care of suicidal risk.
- Hospital emergency departments (ED) play a significant role in assessing and treating mental illness. EDs can be used as an initial point of care for those seeking mental health-related services for the first time, as well as an alternative point of care for people seeking assistance in crisis or after-hours.
- In 2015, there were approximately 65,000 ED occasions of service with a mental health-related principal diagnosis (22% suicidal ideation/self-harm).
- Families and carers play vital roles in safeguarding and improving the health and wellbeing of the people they care for. However, people caring for individuals experiencing a suicidal crisis often have limited access to resources and support.[18]
- A suicidal crisis has a significant negative impact on the overall health and wellbeing of carers. Caregivers may experience persistent stress, shame, anxiety, and guilt[19], resulting in 'caregiver burden'; the emotional, social, and/or financial stress placed on caregivers.[20]
- The ability of support persons to appropriately respond to a suicidal crisis and provide support is influenced by previous experience, knowledge, and available social and personal resources.[18] The provision of appropriate information and resources to families and other support persons may help to reduce caregiver burden and improve the outcomes for the person experiencing the suicidal crisis. Treatment models with proactive carer involvement have demonstrated significant positive improvement for individuals experiencing acute suicidal crisis.[21] The provision of appropriate information and resources to health service providers to support carers is similarly important.

Good practice spotlight

Engaging with and responding to the needs of the suicidal person

The Guidelines are designed to provide recommendations regarding best practice to support healthcare professionals working in Queensland Health emergency departments and mental health alcohol and other drug services to improve the assessment and management of people with suicidal behaviours.

Priority area three: Pathways to care within and outside specialist mental health services

Why is this important?

- Suicide risk is by nature dynamic. An individual's suicide risk status will fluctuate in duration and intensity.[22]
- There is evidence that a person remains at risk of suicide after a suicidal crisis is over. The risk appears greatest in the first year – especially the first six months – after an attempt (remaining high for several years).[23,24] Suicides occurring post-hospitalisation occur predominately during the first month after discharge with the peak of suicides occurring within one week.[25,26]
- The rate of suicide during the first month after discharge has been shown to be more than 100 times the rate in the general population.[27]
- Up to 25% of individuals who re-present to EDs make another attempt following discharge.[29,30]
- Risk may be alleviated by appropriate and systematic follow-up, including assertive outreach where indicated.[31,32]
- Follow up affords an opportunity for reassessment of suicide risk, review of treatment effectiveness, re-evaluation of previously detected 'at-risk' mental states, and collection of further collateral information from family, friends and service providers.
- Several studies have investigated relatively simple, low-cost, low-intensity interventions including letters, crisis cards, telephone contact, and mixed interventions. While further research regarding effectiveness is warranted, a recent review of various contact modalities showed that post discharge follow up can be effective in reducing repeat attempts and suicides.[33] An increase in social connectedness and decrease in perceived burdensomeness that these interventions provide may be the mechanism that makes them effective.[34]
- Too frequently, suicide risk evokes apprehension and avoidance behaviour in health service providers. The promotion of shared responsibility and improvement in linkages between systems will increase health service provider's confidence to address suicide risk more openly and appropriately.
- Mental health system barriers – formalised linkages between different settings is imperative. They include linkages between primary care and specialist mental health care; emergency department care and mental health care; substance abuse and mental health care.
- Structured collaboration between hospitals and teams providing follow-up care has been demonstrated to improve treatment compliance and decrease new attempts.[35]

Good practice spotlight

HealthPathways

HealthPathways (originating in Canterbury, New Zealand) is a web-based information portal supporting primary care clinicians to plan patient care through primary, community and secondary health care systems.

HealthPathways are designed to be used at the point of care, primarily by General Practitioners and are tailored to reflect local resources.

Identified areas for Phase 2 Taskforce investment

Skills development and support

Health related students	Cross sectoral strategic conversation regarding the education and training needs of new staff in health related fields. Development of core competencies in suicide prevention in clinical placements undertaken within Queensland Health.
Supporting Aboriginal and Torres Strait Islander led/facilitated training	Work with the Queensland Mental Health Commission and other key agencies to develop a model of statewide support and coordination for Aboriginal and Torres Strait Islander led/facilitated training.
Culturally diverse groups	Ensure skills development and support resources respond appropriately to the needs of culturally diverse groups including: • Culturally and Linguistically Diverse communities (based on research currently being completed by the Queensland Mental Health Commission). • Lesbian, gay, bisexual, transgender, intersex and/or queer (LGBTIQ+) communities.

Evidence based treatment and care

Sensory-based approaches	Conduct a feasibility study of sensory-based approaches in hospital emergency department settings.
Trauma informed model of care for Aboriginal and Torres Strait Islander persons	Develop protocols relating to the presentation of an Aboriginal and Torres Strait Islander person experiencing a suicidal crisis.

Pathways to care within and outside specialist mental health services

Alternative models of care	Conduct a feasibility study regarding community based models of care such as a place of sanctuary.
Culturally appropriate resources for Aboriginal and Torres Strait Islander individuals, families and workers	Conduct a feasibility study for the development, maintenance and marketing of an online portal of resources for Aboriginal and Torres Strait Islander individuals, families and workers.
Aboriginal and Torres Strait Islander community-based suicide surveillance system for the provision of wrap-around postvention support	Development of pilot project replicating the White Mountain Apache Tribe (WMAT) project occurring in the US adapted to be applicable to an Indigenous Australian population context – requires liaison with the Queensland Mental Health Commission and other key agencies.
Brief interventions	Pilot project in a clinical context to evaluate the effectiveness of brief contact interventions for people with suicide and self-harm risk.
Pathways to care mapping	Map pathways to care for people identified at varying levels of suicide risk.

Appendix A

Please email SuicidePreventionHealthTaskforce@health.qld.gov.au if you would like your organisation's initiative added to the list below. Please note the initiative or activity needs to meet the following criteria:

- Examine suicide prevention issues across the whole of life continuum and pertaining to a health service delivery context.

What is happening?

Education and development

Gatekeepers are people who are likely to come into contact with individuals who are at risk of suicide. Gatekeepers can be divided into two groups:

- Designated gatekeepers – formally-trained persons such as GPs, psychiatrists, psychologists, nurses, and social workers
- Emergent gatekeepers – not formally trained but are potential gatekeepers as recognised by those with suicidal intent, such as family and friends, school and work peers, police, clergy, pharmacists, teachers, counsellors, and crisis line staff.

GP education and capacity building is recognised as one of the most promising suicide prevention strategies. There is a range of education and development programs available which specifically focus on suicide prevention. Appropriateness of programs requires consideration regarding the needs of the intended audience and identified gaps of the workforce.

General practitioners (GP)

- Advanced Training in Suicide Prevention: This accredited program is available for primary care clinicians. The course aims to help participants to undertake a suicide risk assessment effectively and develop a collaborative management plan. www.blackdoginstitute.org.au › For Health Professionals › GPs › Advanced Training in Suicide Prevention.
  - The General Practice Mental Health Standards Collaboration (GPMHSC) has developed mental health first aid resources on suicide prevention and postvention to support general practitioners (GPs) in their day-to-day practice, to recognise and respond to patients whose mental health issues might be risk factors for suicide. This tool kit is not exhaustive and does not replace training. Resources are available from www.racgp.org.au/education/gpmhsc/gp-resources/suicide-prevention/
- Training for healthcare workers: This program provides trainees with a greater understanding of risk assessment, suicide prevention, intervention strategies, and patient support and management. www.wesleymission.org.au › Our services › Wesley Mental Health Services › Wesley Suicide Prevention Services › Suicide prevention – Wesley LifeForce training › Healthcare Workers training

Designated gatekeepers

- Suicide risk assessment and management in emergency department (SRAM-ED): The Queensland Centre for Mental Health Learning, in conjunction with the Clinical Skills Development Service, has developed and delivered a training package using a train-the-trainer model, tailored specifically for ED doctors, nurses and allied health staff, to recognise, assess and appropriately manage people at risk of suicide. Suicide Prevention in Health Services Initiative funding of $620K over three years will support the ongoing implementation of this training program.
- Suicide Prevention Skills Training Workshop for workforces: This course, delivered by The Australian Institute for Suicide Prevention and Research (AISRAP), is for workplaces and organisations. It helps individuals attain knowledge and skills in suicide prevention across prevention, intervention, and postvention. www.griffith.edu.au › Health › Research › Australian Institute for Suicide Research and Prevention › Programs and courses › Suicide prevention skills training.
- Suicide to hope (s2H): This recovery and growth workshop is primarily designed for clinicians and other professional helpers who work with persons previously at risk of and currently safe from suicide. It aims to provide clinicians and other professional helpers with skills to help persons previously at risk identify opportunities for recovery and growth arising out of their experiences with suicide. Find out more at www.livingworks.com.au/programs/suicide-to-hope/

Emergent gatekeepers

- Applied Suicide Intervention Skills Training (ASIST): A two-day interactive workshop in suicide first-aid. ASIST teaches participants to recognise when someone may be at-risk of suicide and work with them to create a plan that will support their immediate safety. For more information go to www.livingworks.com.au › programs › ASIST
- Mental Health First Aid (MHFA): The original 12-hour MHFA course teaches adults how to provide initial support to individuals who are developing a mental illness or experiencing a mental health crisis. Mental health crisis situations covered include suicidal thoughts and behaviours, and deliberate self-harm. Also, Aboriginal and Torres Strait Islander MHFA, MHFA for Nursing Students, Medical Students and Financial Counsellors, Youth MHFA, and Teen MHFA. MHFA for the Suicidal Person (4 hours) will soon be available based on the revised Mental Health First Aid Guidelines for Suicidal Thoughts and Behaviours. Find out more at www.mhfa.com.au
  - MHFA is working with Melbourne University under a NHRMC grant to develop two new short courses for both Aboriginal and Torres Strait Islander Suicide and Non Suicidal self-injury that further explores the cultural considerations in this support. Expected to be rolled out in 2017 and currently on hold.
- Question, Persuade, Refer (QPR) training for individuals and organisations: Offers online and face-to-face courses for gatekeepers. A range of ongoing courses, such as risk assessment and management are also offered. For more information visit www.qprinstitute.com
- headspace School Support: A suicide postvention program, which assists Australian school communities to prepare for, respond to and recover from the death of a student by suicide. It is part of a suite of headspace programs developed to promote mental health and support young people aged 12-25 dealing with difficult issues in their lives.
- UHELP: A community-owned social and emotional wellbeing initiative that involves cultural governance and a group program developed specifically for use with Aboriginal and Torres Strait Islander young people. UHELP groups take a holistic approach – combining physical health, nutrition, social and cultural connection, and activities that promote good mental health and emphasises the importance of connection to Culture.

Evidence based treatment and care

Queensland Health Guides for Suicide Risk Assessment and Management

The Guidelines, renamed 'Engaging with and responding to the needs of the suicidal person' have been reviewed and updated. The Guidelines are designed to provide recommendations regarding best practice to support healthcare professionals working in Queensland Health emergency departments (ED) and mental health alcohol and other drug services to improve the assessment and management of people with suicidal behaviours.

The Guidelines aim to support and complement clinical training in suicide risk assessment and facilitate the delivery of quality, timely, and appropriate suicide risk assessment, management, and ongoing care for individuals, regardless of their point of access. More specifically, the Guidelines have been developed to ensure alignment with SRAM-ED training.

Queensland Health emergency mental health models of care

The Mental Health Alcohol and Other Drugs Clinical Network and the Queensland Emergency Department Strategic Advisory Panel (QEDSAP) funded the Service Evaluation and Research Unit, School of Mental Health at The Park – Centre for Mental Health, West Moreton Hospital and Health Service to conduct a study that examined the extent to which the introduction of the National Emergency Access Target (NEAT) has impacted on the assessment and management of patients presenting with mental health concerns to hospital EDs in Queensland. The study aimed to:

1. Conduct an audit of data contained in the Emergency Department Information System (EDIS) to identify whether the introduction of NEAT had resulted in changes to the assessment and treatment of patients with mental health conditions in EDs
2. Identify factors impacting on the capacity of EDs to treat patients presenting with mental health concerns within the four hour timeframe specified by NEAT
3. Identify implications for policy and practice.

The final report on the study was submitted to the Chair of the Mental Health Alcohol and Other Drugs Clinical Network in September 2016. Following consideration of the final report by the clinical network and QEDSAP, relevant advice will be provided to the Suicide Prevention Health Taskforce.

Psychosocial treatment
Several psychotherapies have been shown to reduce suicidal behaviour including:

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

New Zealand Suicide Prevention Toolkit for District Health Boards
The New Zealand Ministry of Health has developed a Suicide Prevention Toolkit for District Health Boards to support their district health boards to implement suicide prevention and postvention activities within their regions. District Health Boards have a similar role to PHNs in regional planning for suicide prevention. The toolkit includes:

- suicide prevention and postvention plan template
- stakeholder analysis map and analysis tool
- suicide prevention logic model
- plan-do-study-act cycle
- core suicide prevention messages
- suicide prevention workshop and resources

Gold Coast Mental Health and Specialist Services – Zero suicide framework
The Gold Coast Mental Health and Specialist Services (GCMHSS) are currently implementing the Zero Suicide framework within the service. This is a systems approach to suicide prevention that focuses on a number of broad strategies, including leadership to instil the belief that suicides can be prevented in people under the care of a health service, support training and skills development of staff, a continuous quality improvement cycle and embedding research in the work and a 'Suicide Prevention Pathway' that includes engagement, evidence based assessment processes, risk formulation, safety planning interventions, counselling on access to lethal means, and effective transitions of care.

Peer support
Peer support can be defined as 'social emotional support, frequently coupled with instrumental support, that is mutually offered or provided by persons having a mental health condition to others sharing a similar mental health condition to bring about a desired social or personal change'.[36] The central tenet of the peer support 'approach' assumes that people who have similar experiences can better relate and can consequently offer more authentic empathy and validation.[37]

Peer workers are either people (consumers) who have lived experience of mental distress (mental illness) or people (carers) who are loved ones in the life of a person who experiences mental distress. There are three broad types of peer support: informal (naturally occurring) peer support, peers participating in consumer or peer-run programs and the employment of consumers/service users as providers of services and supports within traditional services.[38] Where peers are employed to provide support in services, the individual employed in the support role is generally considered to be further along their road to recovery.[39]

Programs piloting Peer Support Worker Roles within mental health in Scotland have been found to be, on the whole, positive.[41] Peer support offers a unique and complementary role to health service provision and can act as a conduit between clinicians and the individuals experiencing a crisis and their support persons.

A recent review on peer support in mental health services found that Peer Support Worker roles can lead to a reduction in admissions, longer community tenure, increased discharge rates, increased empowerment, improved social functioning, sense of hope and greater feelings of being accepted and understood.[40]

Sensory-based approaches
Sensory modulation involves providing a range of activities that engage the senses in a safe environment. Smell, touch, sight and even taste may be engaged as well as sensory motor functions such as rocking or squeezing to reduce distress, induce calmness and create a feeling of being in control. Evidence is beginning to emerge that this approach can be helpful in avoiding the use of restrictive interventions and in promoting recovery-oriented treatment environments.[42,43]

Sensory-based alternatives and sensory modulation have been recognised as a way of reducing trauma and improving wellbeing among people in a state of psychological distress.[44] Wait times and physical environments of emergency departments can further exacerbate the distress of individuals during crisis. A recent review suggests that utilizing sensory interventions can facilitate a calm state, enhance interpersonal connection, support self-management, promote adaptive emotional regulation, de-escalate arousal, and reduce distress and the rates of restraint.[45]

Sensory modulation approaches have been implemented across various jurisdictions including in Australia. It usually involves setting up sensory rooms accompanied by workforce development to achieve appropriate and effective use of sensory modulation options.

Te Pou o Te Whakaaro Nui (Te Pou) is a national centre of evidence based workforce development for the mental health, addiction and disability sectors in New Zealand. Te Pou has supported District Health Boards (DHB) to embed sensory modulation. Many DHBs now have sensory rooms and use sensory modulation effectively. In some settings, the use of sensory modulation is used as a de-escalation tool and is actively linked to the purpose of reducing seclusion and restraint.[46]

Pathways to care within and outside specialist mental health

HealthPathways
HealthPathways (originating in Canterbury, New Zealand) is a web-based information portal supporting primary care clinicians to plan patient care through primary, community and secondary health care systems. It is like a 'care map', so that all members of a health care team – whether they work in a hospital or the community – can be on the same page when it comes to looking after a particular person.

HealthPathways are designed to be used at the point of care, primarily for General Practitioners but is also available to Hospital Specialists, Nurses, Allied Health and other Health Professionals.

Each health jurisdiction tailors the content of HealthPathways to reflect local arrangements and opinion.

The Queensland Department of Health has purchased the licence for HealthPathways which is now being implemented by PHNs across the state. The suicide prevention HealthPathway provides an opportunity to link GPs to online education and other resources, as well as provide information about services available statewide or nationally.

Brief contact interventions

- Treatment and aftercare of individuals experiencing a suicidal crisis often constitutes a considerable cost burden on healthcare facilities. Many treatments that do exist are relatively resource intensive and require significant prior specialist training.[47]
- Brief contact interventions differ from other forms of outreach care and case management in key ways:
  - Brief contact interventions are not required to be conducted by a mental health professional
  - Occur on a structured schedule and,
  - Delivered over a sustained period of time.[47]
- Can be time limited contact for people discharged after presentation to an emergency department or admission to hospital for intentional self-harm. Contact can take the form of a postcard, letter, or phone call.

- Brief contact interventions typically do not include any formal therapy rather they provide minimal psycho-education or supportive intent.
- Another form of brief intervention is the provision of an emergency access or crisis card (sometimes referred to as 'green cards').[48] The card encourages help-seeking and offers an on-demand crisis admission.[49]
- A recent systematic review and random-effects meta-analysis on randomised control trails using brief contact interventions found a non-significant positive effect on the number of episodes of repeated self-harm or suicide attempts per person.[47]
- Milner and colleagues[47] concluding recommendations were not in support of widespread clinical implementation however "given the possible benefits, low cost and unlikely adverse effects, large-scale trials in clinical populations would be worthwhile' (p.189).

Non-clinical integrated community based support

The Way Back Service
The Way Back Support Service is a low-cost, low-stigma suicide prevention model that delivers person-centred, non-clinical care and practical support in the critical three months after a suicide attempt through assertive outreach. The service aims to prevent repeat suicide attempts and suicide deaths. The service adopts a culturally sensitive, strengths-based and collaborative approach to care. Support Coordinators are recruited from a range of backgrounds and receive training and ongoing support to provide evidence-informed care to people. Following a referral to the Support Service, Support Coordinators contact the client within 24-48 hours.

Community Action for the Prevention of Suicide / TALK Suicide Support Service
Community Action for the Prevention of Suicide (CAPS) has been providing ongoing care and support to young people and adults at risk of suicide and their families and friends since 2008 through its TALK SUICIDE Support Service (TSSS).

TSSS is a strengths-based, person-centred, non-clinical integrated community based response to suicide that strives to fill the gap between crisis response and clinical interventions.

TSSS Client Support Caseworkers coordinate a continuum of care response and work collaboratively with agencies, services and informal supports, whilst maintaining an ongoing and comprehensive support role with the person at risk and their support network. In addition, TSSS work with youth focuses on positive role modelling while assisting them to identify coping strategies to deal with challenges commonly faced by youth today.

CAPS are currently finalising a partnership agreement with Metro South Addiction and Mental Health Services that will enable CAPS to provide comprehensive and ongoing follow up support to individuals at risk of suicide who present to the hospital's emergency departments, contact MHCall and do not meet the requirements for admission or those upon discharge following a suicide attempt with the aim of improving continuity of care and creating positive outcomes.

Maytree (UK)
Maytree provides (up to four) people in the midst of a suicidal crisis with the opportunity for rest and reflection, and gives them the opportunity to stay in a calm, safe and relaxed environment. The service runs 24 hours a day, 365 days a year. Paid and volunteer staff spend up to 77 hours with each guest over their stay, giving them the opportunity to talk through their fears, thoughts and troubles. Maytree offers a free 4-night/5-day stay. It is the only place of its kind in the UK and fills a gap in services, between the medical support of the NHS and the helplines and drop-in centres of the voluntary sector.

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Notes

Suicide Prevention Health Taskforce Phase 1 Action Plan

For more information contact:
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Clinical Excellence Division
Department of Health
GPO Box 48, Brisbane QLD 4001
SuicidePreventionHealthTaskforce@health.qld.gov.au
(07) 3328 9374

Help is available

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 or www.kidshelp.com.au

Support services

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

Harmony Place (mental health services for culturally and linguistically diverse people)
(07) 3848 1600 or http://www.harmonyplace.org.au/default.asp?contentID=616

Queensland Transcultural Mental Health Centre
1800 188 189

headspace
1800 650 890 or www.headspace.org.au

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

Suicide Call Back Service
www.suicidecallbackservice.org.au

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

QLife (LGBTI People)
1800 184 527 or https://qlife.org.au

1300 MH CALL 1300 64 2255
(24/7 centralised phone number for mental health referrals, crisis and support)