

# NSW Suicide Prevention Strategy 2010–2015

A whole of government strategy promoting  
a whole of community approach



Health

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SHPN: (MHDAO) 100234

ISBN: 978-1-74187-503-4

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September 2010

# Foreword

Suicide and attempted suicide are human tragedies with many contributing factors. These acts often occur in circumstances of hopelessness and despair, with there frequently being no single cause and no simple solution. There would be few families in NSW that haven't been touched in some way.

Whilst there has been for some time in New South Wales, an encouraging and ongoing reduction in the rate of suicide, it is important to not become complacent. The NSW Government remains committed to providing a comprehensive response to this human tragedy.

The NSW Suicide Prevention Strategy 2010-2015 sets out the NSW Government's direction and intended outcomes for suicide prevention over the next five years. It is built upon NSW's first suicide prevention strategy *Suicide: we can all make a difference*, and is aligned with the national suicide prevention framework: *Living Is For Everyone (LIFE)*.

The NSW Strategy provides a comprehensive, whole of government approach to suicide prevention in NSW, as well as promoting whole of community involvement through collaboration and partnerships with academics, researchers, non government organisations, service providers, people bereaved by suicide, and families, friends and individuals.

A major focus of the Strategy is to ensure suicide prevention is a shared responsibility, by further strengthening cross government partnerships and strengthening the capacity of individuals, families, schools, workplaces and local communities to work together and share responsibility in supporting each other and the whole community.

The NSW Government also recognises the significant achievements of the non government sector in suicide prevention to date, and acknowledges that building stronger partnerships between government and non government organisations is critical to supporting those at risk of and impacted by suicide.

By developing a shared approach to suicide prevention we will be able to better support individuals and communities to build resilience, encourage social connectedness and promote positive mental health and wellbeing.

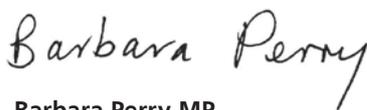
The Strategy includes an accompanying Implementation Plan which sets out for the first time how the Government intends to deliver on its strategic directions. The Implementation Plan will be a 'work in progress' and will reflect adjustments to existing activities or inclusion of additional activities where appropriate. The breadth of government agencies contributing to the Implementation Plan demonstrates commitment to a whole of government approach.

Finally, this framework for action has been developed through an extensive consultation process with our key stakeholders. I would like to thank them for their contribution to the process and commend them for their commitment to work with government to enhance the wellbeing and mental health of the people of New South Wales.



**Carmel Tebbutt MP**

Deputy Premier  
Minister for Health



**Barbara Perry MP**

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## SECTION 1

# Introduction

Suicide prevention is an issue for the whole community and is a priority for the NSW Government – it is everybody's business.

Suicide and suicidal behaviour are complex issues with many contributing factors. There are no single causes and no simple solutions. A whole of government and whole of community collaboration is needed – individuals, families, schools, researchers, community groups and non government services and the private sector – toward a shared approach to suicide prevention in NSW.

There is an ongoing need to understand and manage risk factors while identifying and promoting those protective factors that build individual resilience and encourage social connectivity. Interventions need to be provided in a coordinated and integrated way, addressing priority groups and risk factors in a range of settings based on available evidence and experience.

Suicide is a human tragedy which requires a compassionate response. Comprehensive prevention strategies need to build resilience, awareness and capacity in suicide prevention, provide access to appropriate care and support when and where it is needed, protect those at vulnerable transition points, including the recently bereaved, those who have broken relationships, those at risk of homelessness and those who are entering or exiting institutional settings (schools, health facilities, or correctional facilities), and provide a sense of hope to those affected by suicide – individuals, their families, and our communities.

### 1.1 Purpose of the strategy

This NSW Suicide Prevention Strategy 2010-2015 is the NSW Government's statement of intent to work with the community to reduce the rate of suicide and suicidal behaviour in NSW.

This Strategy sets out the NSW Government's Strategic Directions and intended outcomes for suicide prevention in NSW over the next five years, and is aligned with the national suicide prevention framework: Living Is For Everyone (LIFE).<sup>1</sup>

The Strategy has been developed to provide the basis for a coordinated whole of government approach to suicide prevention in NSW, which promotes a whole of community framework for collaboration and partnerships with academics and researchers, non government organisations, service providers, people bereaved by suicide, and families, friends and individuals in the provision of suicide prevention initiatives.

The Strategy sets out six Strategic Directions which are based on the LIFE action areas:<sup>2</sup>

1. Improving the evidence base and understanding of suicide prevention
2. Building individual resilience and the capacity for self help
3. Improving community strength, resilience and capacity in suicide prevention
4. Taking a coordinated approach to suicide prevention
5. Providing targeted suicide prevention activities
6. Implementing standards and quality in suicide prevention

### 1.2 NSW and Australian policy context

In 1999, the NSW Government released the NSW *Suicide Prevention Strategy – Suicide: we can all make a difference*<sup>3</sup> which provided the first whole of government framework for suicide prevention in NSW and aimed to:

- strengthen individual and community resilience and ability to deal with difficult life situations that contribute to their vulnerability to suicidal acts;
- increase community awareness of suicide as a problem and to better recognise and respond to risk situations;
- prevent, wherever possible, death by suicide;
- reduce the frequency of suicide attempts;
- lessen the adverse consequences of suicide, including its effects on families, friends and communities; and
- provide timely data on suicide deaths and improve the accuracy of information on suicidal behaviour to assist in planning, monitoring and assessing suicide prevention initiatives.

The 1999 Strategy's whole of government framework and five Strategic Directions remain relevant and are built on in the new Strategy. The 1999 Strategy sought to address communities' ability to prevent suicide, provide outreach and support for groups at higher risk, enhance the effectiveness of services in suicide prevention, provide support for people affected by suicide, and improve information on suicide prevention.

A review of actions under that framework indicated that it had achieved improved collaboration across governments, increased investment and better engagement of sectors other than health, and promoted a more holistic approach to suicide prevention in NSW. This result has been achieved through a range of programs and initiatives which either directly address suicide risk, or contribute to reducing risk through improved resilience and wellbeing, detailed at Appendix A.

However, recent consultation with the community has indicated that more needs to be done in terms of:

- further availability of and access to services, especially for people living in rural/remote communities;
- greater focus on at risk population groups;
- better coordination of non health sectors;
- meaningful reporting;
- greater emphasis on evaluation; and
- embracing new approaches, learnings and service models.

There have also been a range of developments in NSW since the introduction of the 1999 Strategy and nationally, which impact on our approach to suicide prevention and are built into the new Strategy. These aim to build wellbeing, resilience and good mental health, and therefore to also avoid the onset of problems such as risk of suicide, including:

- *Keep Them Safe: a shared approach to child wellbeing* – the NSW Government's five year Plan to improve the safety and wellbeing of children and young people;
- *NSW Homelessness Action Plan 2009-2014* and National Partnership Agreement on Homelessness; and
- *Closing the Gap: National Partnership Agreements on Indigenous Health and the NSW Aboriginal Affairs Plan, Two Ways Together, 2003-2012* – the NSW Government's 10 year plan to improve the lives of Aboriginal people and their communities.

There have also been a range of national developments in suicide prevention:

- As indicated above, the NSW Suicide Prevention Strategy 2010-2015 aligns with the current national suicide prevention framework: *Living Is For Everyone (LIFE)*,<sup>4</sup> which provides a national policy for action based on the best available evidence to guide activities aimed at building:
  - stronger individuals, families and communities;
  - individual and group resilience to traumatic events;
  - community capacity to identify need and respond;
  - the capability for communities and individuals to respond quickly and appropriately; and
- a coordinated response, and provide smooth transitions to and between care.
- The Strategy has also been informed by the *Fourth National Mental Health Plan 2009-2014*. This plan requires coordination of "state, territory and Commonwealth suicide prevention activities through a nationally agreed suicide prevention framework to improve efforts to identify people at risk of suicide and improve the effectiveness of services and support available to them".<sup>5</sup> The Plan's desired outcomes include increasing the capacity of communities to prevent mental health problems, mental illness and suicide, and identify and intervene early with people at risk.

In accordance with these developments, the Strategic Directions of the NSW Strategy are based on the six action areas of the LIFE framework, informed by the approach taken to suicide prevention in other jurisdictions, both locally and internationally, and are underpinned by the range of other government policies and programs (as detailed at Appendix B).

### 1.3 NSW driving a shared approach

The NSW Government is responsible for the provision of a range of services, programs and activities that either specifically focus on suicide prevention or respond to the outcomes of suicide or attempted suicide, or aim to enhance the resilience and wellbeing of individuals and the community. These are set out at 2.3 and Appendix A to this document.

However, it is not possible for one government to have in its control all levers and solutions to reduce the risk of suicide and suicidal behaviour.

Accordingly, a shared approach is imperative and to support this, the NSW Government will work with:

- The Commonwealth Government which is responsible, with States and Territories, for development and implementation of national frameworks through mechanisms such as the Australian Health Ministers' Conference. The Commonwealth also directly funds non government organisations to deliver specific services and supports, and provides funding, policy and oversight to General Practitioners and other particular health care professions, for example, specific Medicare Benefits Schedule items provide patients with a mental disorder with better access to psychiatrists, psychologists, GPs and other allied mental health workers.
- Local government, which provides a range of community services that impact on health and/or target vulnerable groups, including home and community care services, youth centres and child care services, as well as health promotion programs and information. Councils also produce individual Community Plans, with targets for groups and key health issues in the community at large, such as reducing the harm associated with alcohol and other drugs, reducing injury, improving diet, encouraging physical activity and promoting mental health.
- The non government organisation sector in NSW, which consists of a complex mix of agencies of varying size with a plethora of objectives, but which all serve the community in one form or another. Some non government organisations receive funding from the State and Commonwealth governments to deliver specific services and supports but they exist independently of government agencies.
- The private sector, which provides specific health services, such as private psychiatrists, psychiatric hospitals, psychologists and is also responsible for providing workplaces that are safe and healthy.
- The community, that is, the individuals, families and groups that make up a community. Communities work together to provide safe and secure environments, and support positive relationships with friends, families, neighbourhoods and community groups. Building a community's capacity and promoting shared responsibility helps a community to protect and support all of its members.
- Above all, the people with a lived experience of suicide, including individuals, families, friends and carers. The Government will strengthen partnerships with this distinct group by listening to their experiences and through this collaboratively build responses that reflect

the advice of those impacted by suicide.

Suicide is an issue for the whole community and, while this strategy specifically sets out the strategic directions for the NSW Government over the next five years, non government organisations play a key role in suicide prevention activities and we must work together to ensure a shared approach to this important work.

The NSW Government acknowledges that building stronger partnerships between government and non government organisations is critical to supporting those at risk of and impacted by suicide. By developing a shared approach to suicide prevention we will be able to support individuals and communities to build resilience and encourage social connectedness, promoting positive mental health and wellbeing.

The NSW Government also recognises the significant achievements of the non government sector in suicide prevention to date. This Strategy sets out how the NSW Government will address suicide prevention over the next five years, however, it is also intended that the Strategy will provide a platform for greater collaboration with the non government sector in this field.

## 1.4 Development of the strategy

The NSW Suicide Prevention Strategy 2010-2015 was developed through extensive consultation and collaboration between the NSW Government and a wide range of stakeholders, including through two forums on the development of the Strategy in July and October 2009 attended by consumers, families and carers, non government organisations, service providers and academics.

As detailed at Appendix C, those consulted brought a wealth of experience and expertise to the development of the Strategy across the areas of:

- personal experience with suicide or suicidal behaviour;
- government policy;
- community and carer experiences;
- clinical care;
- Aboriginal health;
- drug & alcohol services;
- young people;
- older people;

- the criminal justice system;
- media and advocacy;
- research and expert advice; and
- charity and support services.

Key issues identified through this process, and which have been incorporated into this document include:

- suicide and suicide prevention are whole of society issues;
- emphasis should be placed on individual and community capacity and resilience;
- the importance of system responses and continuity of care for those at risk of suicide should be recognised;
- the potential for using new technologies to reach young people and other at risk groups should be maximised;
- suicide prevention activities should aim to develop a sense of place and promote connectedness to the community;
- it is important for individuals to understand they can recover from a suicide attempt and reconnect with the community and support services; and
- activities to be driven by the new Strategy need to be within the scope of a State government.

## 1.5 Structure of the strategy

This document is structured to set out clearly:

- the policy context in which the Strategy has been developed (chapter 2);
- the principles governing suicide prevention work in NSW (chapter 3);
- the model and priority areas for suicide prevention in NSW (chapter 3);
- the Strategic Directions for suicide prevention, the outcomes we want to achieve, the actions required to do this, the initiatives to support this, and the ways that we will measure the impact (chapter 3);
- the governance, implementation, monitoring and reporting approach for the Strategy (chapter 4); and
- how we will evaluate our work, and apply this knowledge (chapter 5).

# Why do we need a suicide prevention strategy in NSW?

## 2.1 What is the size and scope of the problem?

In Australia, the latest available data indicates that the death rate from suicide was 10.1 per 100,000 population in 2008.<sup>6</sup>

The suicide rate in Australia can be considered within the context of other countries, and the table below shows the rates in different countries, collected by the World Health Organization in 2007, using the latest available data at that time. Australia has a higher rate than some countries, and lower than others. Measuring rates of suicide against other countries is complex due to a number of factors; countries differ, methods of suicide may vary between cultures, coronial decisions may vary between countries, there are cultural differences in the way suicide is viewed, data collection of deaths may vary, as does the frequency of reporting of suicide deaths.<sup>7,8</sup> As such, making true comparisons between countries is problematic.

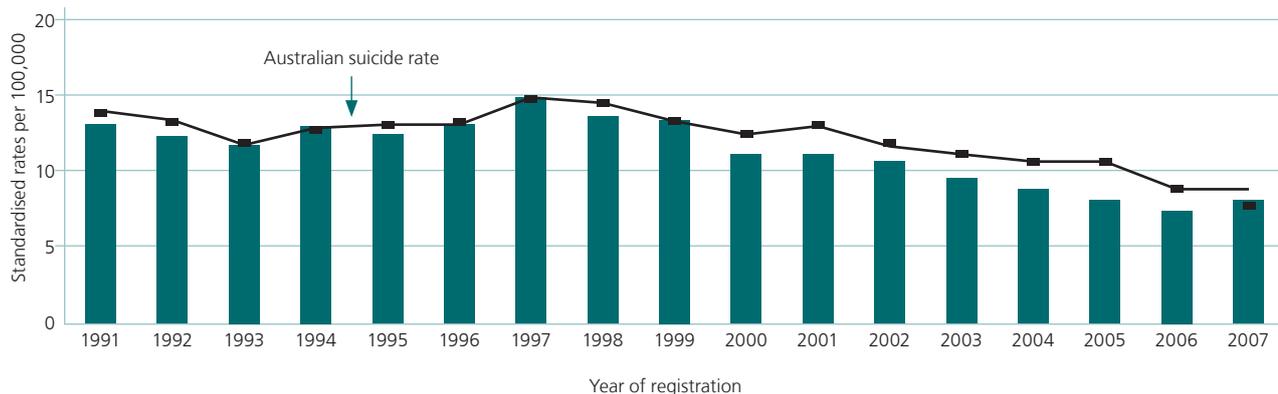
NSW has the lowest rate of suicide in Australia, 7.8 per 100,000 population in 2008.<sup>10</sup> As set out at figure 2.2, both the national and NSW rates have reduced significantly since 1997, when the Australian rate was 14.6 and the NSW rate was 14.8 per 100,000 population.<sup>11</sup>

The NSW Government recognises limitations of the data on suicide and the care required in interpreting numbers of suicide deaths. Reliability of suicide statistics has been affected by a number of factors including the differences in reporting methods across Australia and delays in the processing of possible suicides by coroners. This has been recognised by The Australian Bureau of Statistics (ABS), with a quality assurance process completed in March 2010 to improve the quality of coding of deaths data, resulting in more accurate reporting of all causes of death, including suicide.<sup>12</sup>

Figure 2.1: Suicide rates (per 100,000 for selected countries) (latest year available when collected in 2007)<sup>9</sup>

Country	Year	Suicide rate	Country	Year	Suicide rate
Greece	2004	3.2	New Zealand	2004	11.7
Brazil	2002	4.3	Germany	2004	13.0
United Kingdom	2004	7.0	Sweden	2002	13.2
Italy	2002	7.1	Cuba	2004	13.5
Spain	2004	8.2	Denmark	2001	13.6
Argentina	2003	8.7	Poland	2004	15.9
Netherlands	2004	9.3	Austria	2005	16.9
Ireland	2005	9.7	Switzerland	2004	17.4
Singapore	2003	10.1	France	2004	18.0
Australia	2005	10.3	Finland	2004	20.3
Chile	2003	10.4	Republic of Korea	2004	23.8
USA	2002	11.0	Japan	2003	24.0
Norway	2004	11.5	Hungary	2003	27.7
Canada	2002	11.6	Russian Federation	2004	34.3

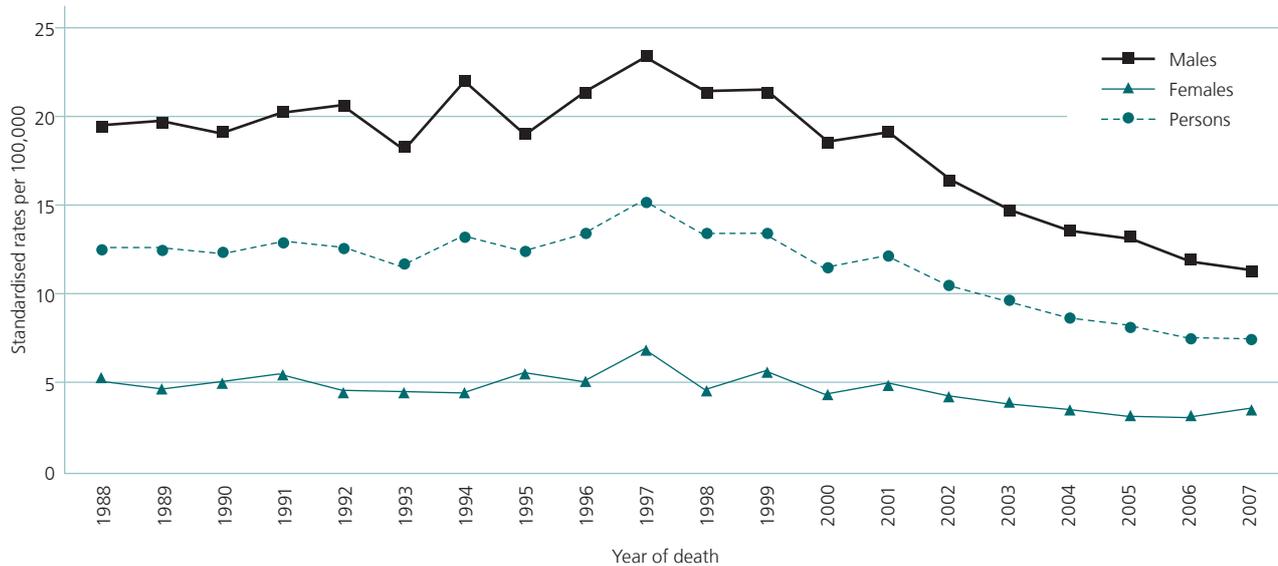
Figure 2.2: Standardised suicide rates, by year of registration, NSW vs. Australia, 1991-2007<sup>13</sup>



While the downward trends are encouraging, the risk of suicide remains a concern for governments across Australia, with it often the case that there is not as great an awareness of its extent across the community as there is awareness of

other causes of death. For example, more people continue to die from suicide than road injury in NSW. In 2007, there were 7.9 suicide deaths per 100,000<sup>14</sup> people compared to 6.3 road injury deaths per 100,000 people in NSW.<sup>15</sup>

Figure 2.3: Standardised suicide rates by sex, persons of all ages, NSW, 1988-2007<sup>16</sup>



However, deaths from suicide are only part of the problem of suicidal behaviour in NSW. It is estimated that for every suicide death, 30 to 40 people attempt suicide each year in NSW.<sup>17</sup>

There are also many problems associated with the accurate reporting of suicide attempts. Information that is collected about attempted suicide is usually based on hospital admissions only, and may exclude people who are discharged from the emergency department, those who see a general practitioner, or those who do not seek any medical assistance.<sup>18</sup>

## 2.2 How do we recognise risk?

Suicide is a highly complex issue with many contributing factors. Individual determinants can apply to a number of different population groups in the community including Aboriginal people and include poor mental or physical health, alcohol and other drug use, identifying as gay, lesbian, bisexual or transgender, a history of suicidal behaviour, and having little sense of control over life circumstances and poor coping skills.<sup>19</sup>

In addition to these individual determinants, broader social and contextual factors can also increase risk of suicide. Social determinants include living in rural and remote areas, social isolation, imprisonment, bereavement, abuse and violence, and the breakdown of family and personal relationships; while contextual determinants can include homelessness, unemployment or financial strain, or transition from institutional settings.<sup>20</sup>

However, not all individuals with these determinants are at risk and those that are may only be at risk at certain points in their life. The majority of people who can be categorised as at risk do not, and will not ever take their own life.<sup>21</sup>

Equally, there are a number of protective factors which reduce the likelihood of suicidal behaviour and improve a person's ability to cope with difficult circumstances. One of the key aims in suicide prevention is to develop these

protective factors in individuals and communities, including resilience; self esteem, secure identity and sense of purpose; problem solving and help seeking; and good physical health and wellbeing.<sup>22</sup>

### 2.2.1 Individual determinants

#### Gender

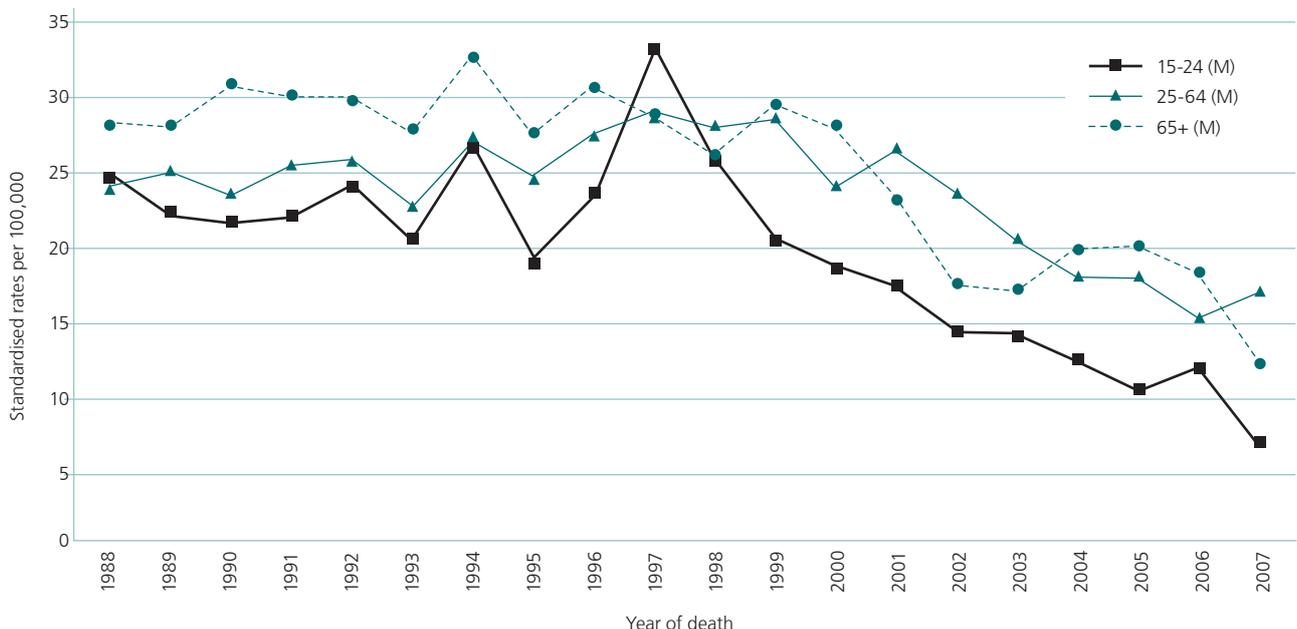
While men have higher suicide death rates than women, suicidal behaviour is an equally serious problem for both women and men.

Suicide rates in men continue to decline, however suicide accounts for more than 15 per cent of all deaths among Australian men aged between 20 and 44 years, and as much as 26 per cent in the 20 to 24 year age group.<sup>23</sup> Males account for over 75 per cent of suicide deaths in NSW.<sup>24</sup>

While men of all ages and backgrounds can be at risk of suicide, the data suggests that those with the highest rates of suicide are:

- aged 25-65 years – suicides among this age group comprised 78 per cent of all male suicide deaths in 2007;<sup>26</sup>
- aged 65 and over – in 2007, the age-specific suicide rates for men older than 65 years was 12 per 100,000;<sup>27</sup>
- Aboriginal men;
- men living in rural or remote areas; and
- those in correctional settings.

Figure 2.4: Age-specific suicide rates for males by age group, NSW, 1988-2007<sup>25</sup>



Drug and alcohol use, depression, relationship problems, unemployment, financial difficulties, and work stress have been suggested as contributing factors for suicide in men.<sup>28,29</sup> Men also tend not to recognise or respond to their own emotions<sup>30</sup> or seek help or communicate their feelings.<sup>31</sup> This may be due to a belief that this behaviour shows weakness<sup>32</sup> or that they are unaware of available support services.<sup>33</sup>

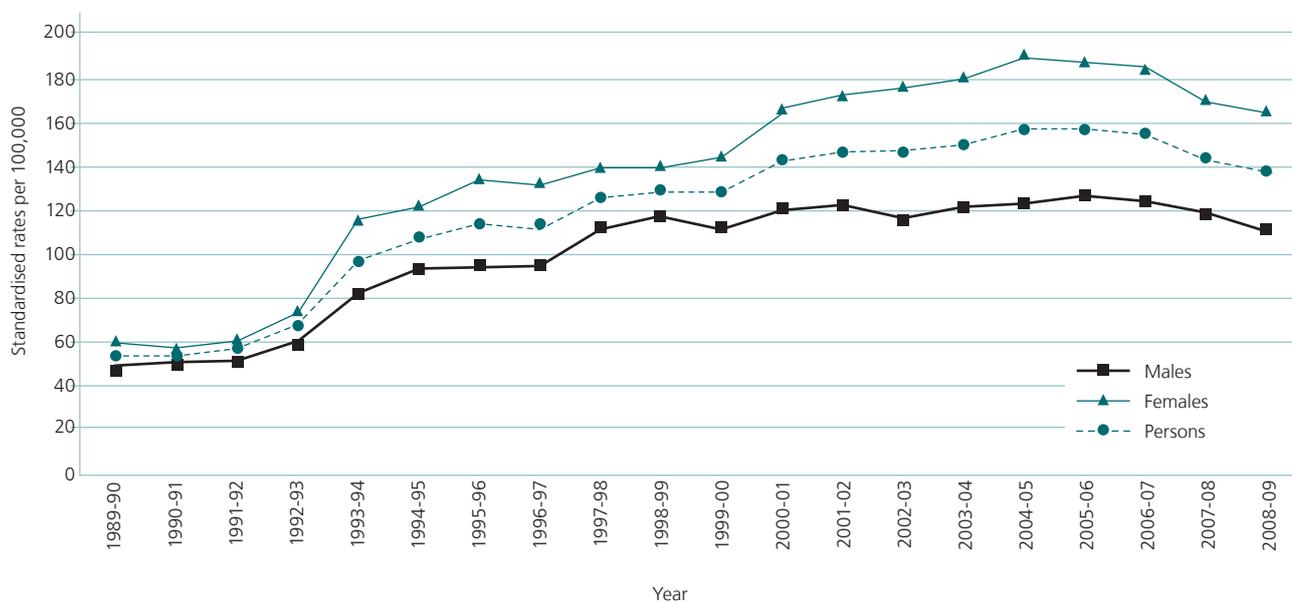
The 2007 data indicates that hanging was the most frequent method of suicide death for men in NSW, followed by poisoning by gas. For women, the most frequent causes of death were hanging, followed by tranquilisers, psychotropic agents and other unspecified drugs.<sup>34</sup>

Men are more likely to use more lethal methods than women,<sup>35</sup> however, evidence shows that women are more likely to attempt suicide. When suicide deaths are combined with serious suicide attempts resulting in hospitalisation, the difference between men and women becomes smaller.<sup>36</sup>

The rate of suicide attempts for women is of concern, given that those who have made previous suicide attempts have a 10 to 30 fold increased risk of suicide.<sup>37</sup>

As a consequence, this evidence suggests that suicide prevention should target both males and females, as they are equally at risk of suicidal behaviour.<sup>39</sup>

Figure 2.5: Standardised hospitalisation rates for intentional self-harm by sex, persons of all ages, NSW, 1989-90 to 2008-09<sup>38</sup>



## Age

Suicide rates in NSW for young people are now below those of the general population with the suicide death rate for young people aged 15-24 years falling to 5.9 per 100,000 in 2008, the lowest in Australia.<sup>40</sup>

Despite these trends, youth suicide and suicidal behaviour remains a significant issue for individuals as well as communities.<sup>41,42</sup> Factors such as depression, disruption to psychological, educational and social development, legal or disciplinary problems, parental illness or divorce and strain on personal relationships (for example, breaking up with a girlfriend or boyfriend) can increase risk of suicide in young people.<sup>43,44</sup> The hazardous use of alcohol and other drugs by young people can also increase suicide risk.<sup>45,46</sup> Further, the impact of emerging issues such as cyber bullying need

to be addressed, as well as the risk of contagion or copycat suicides.<sup>47</sup>

A study of trends in deaths for children and young people aged 10-17 years in NSW from 1996 to 2005 found around 13 per cent were the result of suicide. Of these:

- 66 per cent were in the context of enduring difficulties such as mental health problems, family dysfunction and school related difficulties; and
- 22 per cent occurred after a pivotal life event such as experiencing interpersonal problems, physical illness or accidents, sexual assault, losing a job or legal problems.<sup>48</sup>

The rate of suicide is estimated to be higher in older people (65 years and over), particularly older men, than for the population as a whole, with it noted that suicide may be underreported among the elderly, with some types of suicide, such as poisoning by certain drugs, appearing consistent with death by a natural cause, such as myocardial infarction.<sup>49,50</sup>

Family conflict, serious physical illness, loneliness or loss of a partner, and depression are associated with suicide in those aged 75 and above with better recognition and treatment of depression a key factor in suicide prevention in this age group.<sup>51</sup>

### ***Aboriginal people and communities***

The suicide rate for Aboriginal people in specific communities is as much as 40 per cent higher than that for the Australian population as a whole<sup>52</sup> while suicide risk for Aboriginal males 15 to 19 years has been identified as four times that of the general population.<sup>53</sup>

A study of trends in mortality and hospitalisation in Aboriginal populations in NSW undertaken between 2000 and 2007 shows 12 per cent of all Aboriginal deaths during this time were a result of injury or poisoning, with a quarter of these deaths attributed to suicide, particularly in the younger age groups.<sup>54</sup> Aboriginal males were at high risk of hospitalisations for self-harm injuries and suicide, whereas Aboriginal women were at high risk of hospitalisation for self-harm. In addition Aboriginal females were twelve times more likely than non-Aboriginal females to be hospitalised due to interpersonal violence.<sup>55</sup>

However the available data for Aboriginal communities should be treated with caution. This is partly due to the limitations of official methods of collecting data about Aboriginal populations and difficulties in estimating the size of the Aboriginal population in each age group. The available data on population estimates, hospitalisation and mortality rates are likely to be an underestimate.<sup>56</sup>

According to the LIFE framework, the high suicide rate among Aboriginal people is due to a number of factors including poverty, low socioeconomic status, lack of education and poor employment prospects, reduced access to culturally appropriate services, poor overall health, living in rural or remote communities, high rates of incarceration, domestic violence or abuse, and alcohol and other drug abuse.<sup>57</sup> The interrelated nature of these factors can lead to a cycle of despair and depression.

Many Aboriginal people have also been personally affected by the suicide of someone to whom they were close. This lessens a social barrier to the acceptability of suicidal behaviour as a solution to overwhelming problems, and at least introduces suicide as an option.<sup>58</sup>

The determinants of suicide and attempted suicide in Aboriginal communities frequently start before an individual is born, and have much to do with the interrelated presence of intergenerational trauma and grief, dislocation and mistreatment, loss of cultural identity and social isolation, and current grief from the deaths of family and community members.<sup>59</sup> The Strategy recognises that Aboriginal culture is holistically based<sup>60</sup> and mental health is an inseparable part of spiritual, cultural and social wellbeing, with the wellbeing of the individual, family and community inextricably linked.<sup>61</sup>

### ***Mental illness***

People with a mental illness are at a greater risk of suicide than the general population.<sup>62</sup> According to the LIFE framework, the strongest associations between mental illness and suicide include depression, anxiety, bipolar disorder, schizophrenia, alcohol and other substance use disorders, personality disorder and behavioural disorders in children and adolescents.<sup>63 64</sup> Studies also indicate other associated mental disorders, such as post traumatic stress disorder, prevalent in the veteran community, may increase risk of suicide.<sup>65</sup> The risk of suicide further increases among individuals experiencing more than one of these mental illnesses at any one time.

Among young people, a NSW study found depression was the most common diagnosis for those who died by suicide.<sup>66</sup> The study also found that approximately 11 per cent of young people had not been diagnosed with a mental illness, although they were "clearly suffering from a mood state that was causing obvious distress".<sup>67</sup>

Poor mental health is also associated with suicide risk in older age groups, particularly when combined with negative life events including separation and divorce, loss of a partner or child, family conflict or unemployment.<sup>68</sup> Many people do not seek treatment for their mental illness with people aged 75 and above less likely to have received treatment for their depression than their younger counterparts.<sup>69</sup>

However, not all people with a mental illness display suicidal behaviour, nor do all those who die by suicide have a mental illness.<sup>70</sup> Suicide is not simply a mental health issue.

### ***Alcohol and other drugs***

Alcohol and other drugs are frequently associated with suicidal behaviour.

Acute alcohol use may increase suicide risk up to 90 times, in comparison to abstinence,<sup>71</sup> with intoxication often predicting the use of more lethal means in suicide.<sup>72</sup>

Alcohol may also play a part in the suicide deaths of those with no previous mental illness or suicidal ideation.<sup>73</sup>

Reduced inhibition and increased impulsivity, including risk taking behaviour, resulting from alcohol intoxication may increase the likelihood of suicidal thoughts and suicide.<sup>74,75</sup> A NSW study of violent deaths found that in 66 per cent of violent suicides (that were not a direct result of substance toxicity) a substance was detected, including 38.7 per cent in which alcohol was detected.<sup>76</sup>

Acute alcohol use and binge drinking is strongly associated with suicide and suicide attempts among young people.<sup>77</sup>

Alcohol dependence is also an important risk factor for suicidal behaviour, with studies suggesting this risk increases with age.<sup>78,79</sup> Depression, poor social support, living alone, feelings of hopelessness, comorbid substance abuse and serious medical illness are all strongly associated with suicidal behaviour in individuals with alcohol dependence.<sup>80</sup>

A strong relationship also exists between suicide and the use of other drugs. Evidence indicates that opioid dependent individuals are 14 times more likely to die by suicide than non opioid users.<sup>81</sup> Mood disorders, childhood physical and sexual abuse, poor family relations and unemployment may also contribute to suicide risk for those using opioids.<sup>82</sup>

Suicide and attempted suicide is commonly linked to non opioid drugs and alcohol among patients on the methadone program, with the most common method reported to be overdose using benzodiazepines.<sup>83</sup>

Suicide risk has also been found to be higher than that of the average population among cannabis and cocaine users, particularly when co-occurring with a mental health condition such as anxiety or depression.<sup>84</sup> The use of psychoactive substances also appears to increase the likelihood of suicide attempts in those with suicidal ideation, with it suggested that cannabis increases the risk of suicidal behaviours indirectly, through reduced control and increased impulsivity.<sup>85,86</sup>

### ***Poor physical health***

Poor physical health, including chronic illness or severe pain, may increase risk of suicidal behaviour,<sup>87</sup> particularly among individuals with depression.<sup>88</sup>

Physical illness, including cancer, cardio pulmonary disease, pain arising from osteoarthritis, visual impairment and neurological disorders, is one of the most frequent events preceding suicide in older people.<sup>89</sup>

Poor physical health such as injury, asthma, and symptoms or signs of infectious diseases have also been linked to increased risk of suicide in young people, particularly when coupled with depression or other mental illness.<sup>90</sup> The incidence of suicide of people with a spinal cord injury has also been shown to be five times higher than the general population, with heightened risk in the first five to six years post injury.<sup>91</sup>

### ***Gay, Lesbian, Bisexual and Transgender***

Evidence suggests that the rate of suicide attempts for Gay, Lesbian, Bisexual and Transgender (GLBT) people is 3.5 to 14 times higher than for the general community while suicide and self-harm rates for same sex attracted youth and GLBT Aboriginal people are even higher.<sup>92</sup>

The experience of homophobia, transphobia and discrimination, violence and abuse, social isolation, abuse of alcohol and other drugs and mental health issues all contribute to the elevated risk of suicide in the GLBT community.<sup>93</sup>

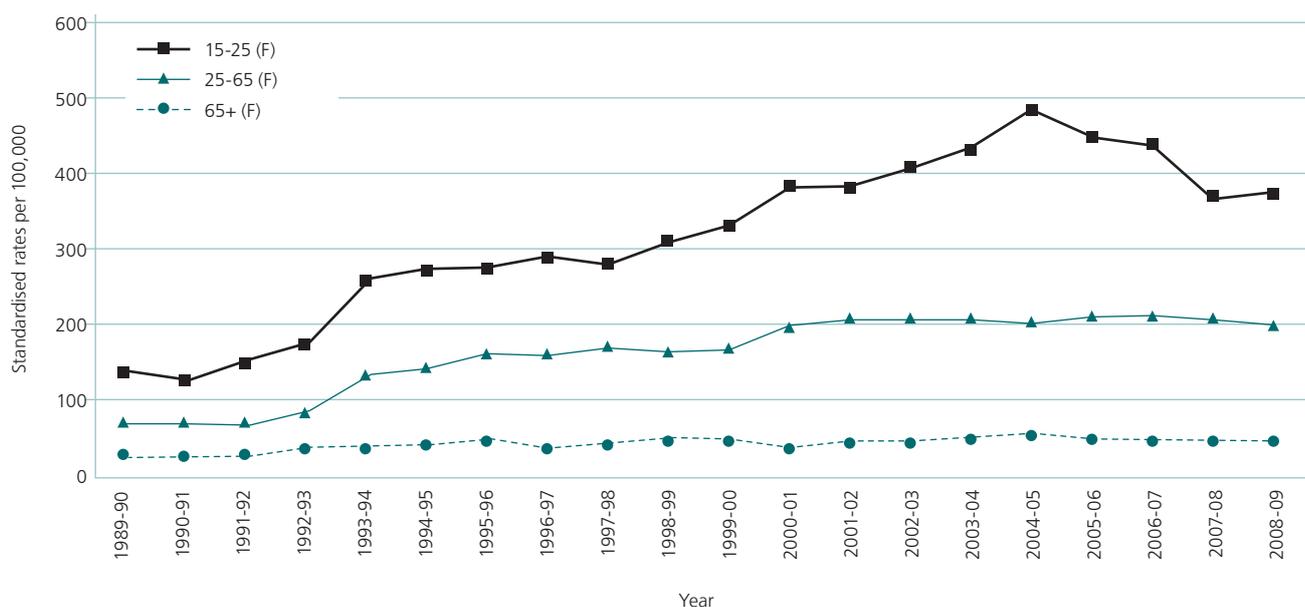
### ***History of suicidal behaviour or self-harm***

In considering the above individual determinants, it needs to be taken into account that a previous suicide attempt is the strongest independent risk for suicide<sup>94</sup> and as such, should be addressed in any suicide prevention strategy.

It can be difficult to distinguish between self-harm and suicidal behaviour and while those who self-harm may or may not have suicidal thoughts, non suicidal self-harm also remains a strong risk factor for suicide.<sup>95</sup>

As shown in Figure 2.6, the numbers of young females aged 15-24 hospitalised for self-harm has begun to fall after a peak in 2004-05 (483.0 per 100,000), however the numbers remain significantly higher than among any other age group (468.5 per 100,000 population for females aged 15-24 compared to 154.2 per 100,000 for females of all ages in 2008-09).<sup>96</sup>

Figure 2.6: Age-specific hospitalisation rates for intentional self-harm by age group, for females, NSW 1989-90 to 2008-09<sup>97</sup>



A family history of suicide is also a risk factor to suicide. Family, twin and adoption studies indicate that suicidal behaviour has an underlying genetic predisposition, suggesting a family history of suicide may increase an individual's risk of suicide.<sup>98, 99, 100, 101</sup>

## 2.2.2 Social and contextual determinants

### People bereaved by suicide

Suicide causes devastation among family, friends, colleagues and local communities.<sup>102</sup> Reports suggest that those bereaved by suicide are more likely to experience intense grief, suicidal thoughts and behaviours.<sup>103,104</sup>

There are a number of issues associated with suicide bereavement, including:

- feelings of isolation and stigmatisation;
- the risk of contagion or copycat suicides, particularly among adolescents and young adults;<sup>105</sup>
- difficulties around how to talk about suicide in families, schools, workplaces and communities;
- the impact on those who witness a suicide or first respond to a suicide;
- the importance of training for professionals dealing with those bereaved by suicide (e.g. mental health clinicians, other health professionals, teachers, workplace counsellors etc); and
- the influence of media reporting.

### Abuse and violence

Traumatic life events such as interpersonal violence, including workplace and schoolyard bullying, domestic violence, child abuse and neglect and sexual abuse are associated with higher rates of suicidal ideation and behaviour.<sup>106</sup>

All forms of neglect (physical, emotional and environmental) are associated with measurable developmental harm to a child's physical, cognitive, emotional and social functioning. The effects may emerge at the toddler stage and endure into adulthood. Children who have been abused may have attachment difficulties compounded by a lack of the social skills necessary for peer relationships. They may be socially isolated and lacking protective factors, putting them at risk for suicidal behaviour.

### Family and relationship breakdown

Studies indicate that marital status is associated with the level of risk of suicide. Studies have shown that in comparison to people who have never married, married people have lower rates of suicide risk, whilst people who are divorced, widowed or separated are associated with having a higher risk of suicide.<sup>107</sup> According to a NSW study, more than 62 per cent of precipitating incidents to the suicide deaths of young people involved a relationship breakdown or argument with a significant person in their lives.<sup>108</sup> Further, a seven year study of murder-suicides in Australia indicated that, while numbers are small, two thirds of murder-suicides involved people in a family, particularly partners and children.<sup>109</sup>

Young people in out-of-home care may be particularly vulnerable and susceptible to suicidal thoughts and/or attempts due to their past experiences of attachment disruption, abuse and trauma and their current circumstances. The high incidence of suicide in children who have been abused has been noted in several studies.<sup>110</sup> Abuse and trauma have a marked effect on emotional regulation leading children and young people to be extremely reactive and impulsive. This is important when considering that many suicides are impulsive acts.

### ***Contact with the criminal justice system***

Risk of suicide increases among those who have had contact with the criminal justice system.<sup>111</sup> High rates of mental illness are evident at all points in the criminal justice system, among victims of crime and offenders, including both offenders sentenced to prison, and those that receive community orders.

Studies in NSW have reported that a high number of defendants report one or more signs of psychiatric disorder, often with dependent or disordered substance use.<sup>112,113</sup> In NSW, 18 per cent of offenders newly admitted into the NSW correctional system had thought about suicide in the previous 12 months. Of those who had thought about suicide, 59 per cent had made a suicide plan, with over half of this group attempting suicide.<sup>114</sup>

Factors that bring young people to the attention of the juvenile justice system also make them vulnerable to suicidal thoughts and behaviours.<sup>115</sup> A NSW survey of young people on community orders found that young females on community orders were more likely to have considered suicide than those in custody, whereas the converse was true for young males.<sup>116</sup>

### ***Contact with the correctional system***

Suicide has consistently been reported to be much higher in offender populations than the general community. Between 1995 and 2005, suicide was the leading cause of death among NSW inmates with the rate of suicide approximately 10 times that of the general NSW community.<sup>117</sup>

A study into mental illness among NSW offenders in 2003 found that 16 per cent of all inmates had suicidal thoughts in the previous twelve months, 10 per cent had made a suicide plan and 5 per cent had attempted suicide.<sup>118</sup> The preliminary results of a survey of young people in juvenile facilities indicate that approximately 16 per cent have ever thought about suicide and 10 per cent had attempted suicide.<sup>119</sup>

Risk factors for suicide are common among offender populations and include younger age, male, psychological distress, chronic physical illness, drug and alcohol abuse, and previous suicide attempts.<sup>120,121</sup>

### ***Transition from institutional settings***

There can be an increased risk of suicide at transition points in life. For example, transition to and from high school (or between high schools), mental health facilities, different criminal justice settings, correctional facilities, and transition from institutions to the community.

Children and adolescents entering or changing schools may not integrate into a friendship network, lack involvement and social connectedness, and experience loneliness or stigma.<sup>122</sup> Equally, leaving school can also be a major stressor impacting upon students' wellbeing.<sup>123</sup>

A high proportion of people who die by suicide are known to the health service. Individuals experiencing mental illness are at greatest risk of suicide immediately following discharge from psychiatric inpatient care.<sup>124</sup> This is a key priority for the Strategy, in terms of the way they are managed within the system as well as getting people in touch with services early.

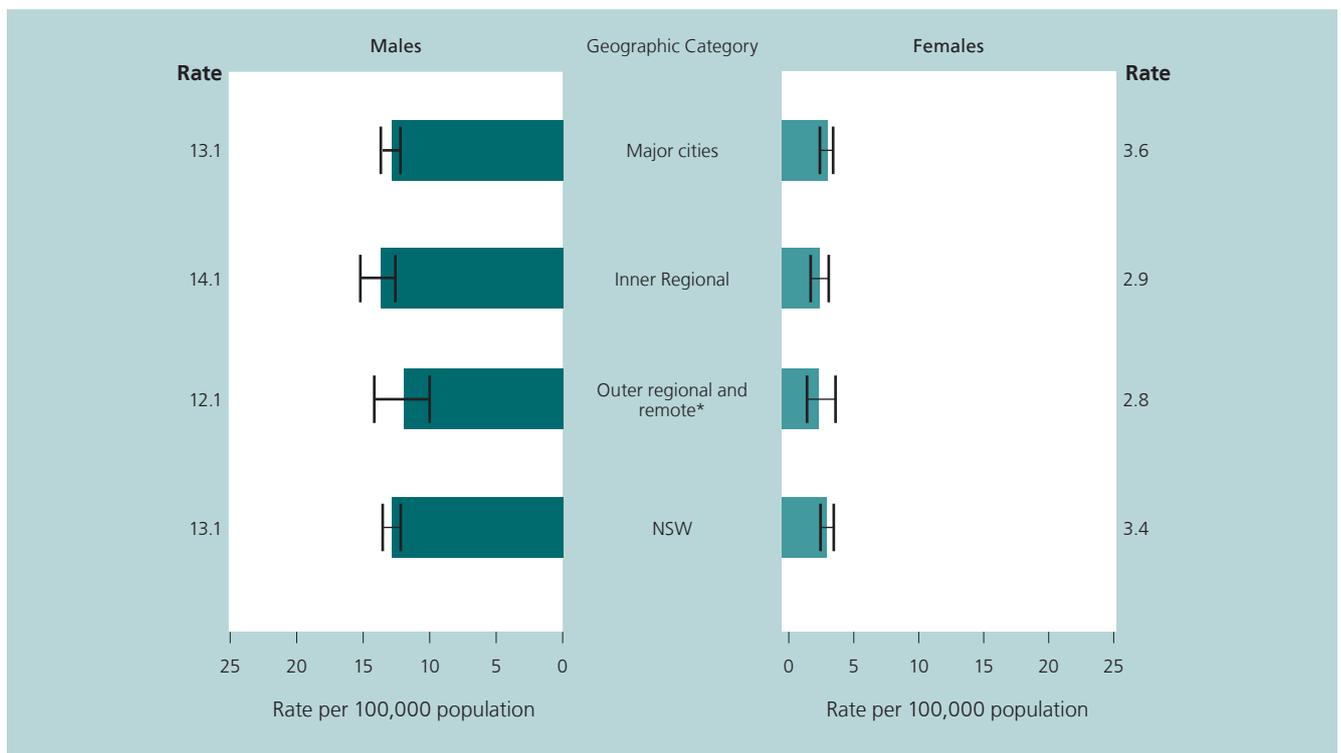
The rate of suicide is higher among released offenders than those in custody, with a study of adult offenders finding an increased risk of death from suicide in the period immediately following release from prison in NSW. The rates of suicide among released offenders did not return to custodial levels until six months following release, suggesting that a significant period of adjustment to life in the community is required for vulnerable offenders.<sup>125</sup> This study suggested that the period after release is a time of extreme vulnerability with issues such as social isolation, lack of support including appropriate housing, poor coping skills, and their transient nature contributing to the level of risk for this group. Offenders who are released with no parole period are particularly vulnerable.

### ***Rural and remote populations***

Suicide rates in rural NSW are higher than urban areas, especially for men.

Over the five year period 2002 to 2006, the suicide age-adjusted rate in NSW was 8.7 per 100,000 population. Over that period, people living in Local Government Areas (LGAs) classified as outer regional and remote had the highest rate of suicide (10.0 per 100,000 population) due to a high rate for males (16.3 per 100,000).<sup>126</sup> There was no difference in the rates of suicides for females between those living in major cities, inner regional or outer regional and remote areas.

Figure 2.7: Suicide by remoteness from service centres and sex, NSW 2002-2007 combined<sup>127</sup>



The LIFE framework suggests a number of reasons for the higher rates of suicide in rural and remote areas:<sup>128</sup>

- financial hardship due to changes in the economy and extreme weather events;
- easier access to more lethal means;
- social isolation and poor social networks;
- reduced access to services; and
- less help seeking behaviour.

### Homelessness

Homeless people appear to experience higher rates of suicidal thoughts,<sup>129</sup> attempted suicide,<sup>130,131</sup> and suicide<sup>132,133</sup> compared to the general population. This may be explained by a higher prevalence of mental illness and alcohol and substance use comorbidity among the homeless.<sup>134,135,136</sup> Vulnerability to homelessness is also heightened during transition stages, such as leaving education, leaving the child protection system, family breakdown, retirement, leaving prison, or relocating.<sup>137</sup>

### High risk occupational groups

Certain occupational groupings are at high risk of suicide. Studies from Australia and New Zealand have demonstrated higher suicide rates for those working in farming, fisheries, forestry or trades than the general population.<sup>138,139</sup> Rates have also been shown to be high among medical practitioners.<sup>140,141</sup>

### Unemployment and financial stress

Socioeconomic status and employment has been linked to risk of suicide among young males. In recent years, whilst suicide has declined in young males in middle and high socioeconomic groups in Australia, there has been a continued increase in suicide among males of low socioeconomic status, and elevated risk among young males who are not working or studying.<sup>142,143,144</sup>

Suicidal ideation and attempts are common among income support recipients such as the unemployed, lone mothers and disability payment recipients.<sup>145</sup>

Adjusting to retirement and financial debt may also contribute to increased risk of suicide in those aged 50 years and over.<sup>146</sup> High rates of suicidal ideation are also found in populations of pathological gamblers, a group who also exhibit elevated levels of depression.<sup>147</sup>

### People from culturally and linguistically diverse backgrounds, migrants and refugees

Some people from culturally and linguistically diverse backgrounds are at higher risk of suicide with rates among these groups often similar to those of their country of birth.<sup>148</sup> This risk is greater for elderly immigrants<sup>149</sup> and for male immigrants residing within rural NSW<sup>150</sup> and may be the result of poor expectations of the future, social

isolation, belonging to a lower social class or encountering language barriers.<sup>151</sup>

Refugees who have experienced or witnessed trauma, torture, assault or abuse may also be at higher risk of suicide.<sup>152</sup>

### **Access to lethal means of suicide**

Restricting means of access to suicide, including gun law reform and restriction of access to barbiturates, has been linked to significant reductions in suicide rates although method substitution must also be considered.<sup>153</sup>

### **Media reporting**

As reported in the LIFE framework, there is strong evidence linking media reports of suicide to increased suicide rates both overseas and in Australia.<sup>154</sup> However, the development of guidelines regarding the responsible coverage of suicide in the media has had an impact on the way in which suicides are reported, and on reducing suicide behaviours.<sup>155</sup>

## **2.3 What this means for the NSW Government**

The range and complexity of factors which can contribute to suicide mean there is no single priority group for suicide prevention activities, and suicide prevention requires a whole of community response. Across NSW Government services a focus is given to the suicide risk factors which are most likely to be prevalent among an agency's client groups, and the approaches to suicide prevention which are most likely to be effective for those groups. For example:

- The **Health system** has responsibility for a range of issues across society as a whole, and in particular for people at risk, including the promotion of mental health and wellbeing, the prevention of mental ill health and drug and alcohol ill health, identification and management of risk of suicide, and ongoing care and support. Management of patients with possible suicidal behaviours should be integrated and coordinated across each health service and facility, with presentations of people with suicide risk assessed and treated as an emergency. In addition to prevention and recovery oriented community based mental health services and a range of cross agency preventative health initiatives, a range of protocols and initiatives are in place to identify people at risk of suicide and improve responses to suicide, including:
  - a suicide risk assessment and management framework and training program for the Health system to enhance the capacity of health workers to assess and effectively manage people who may be at risk of suicide, including specific protocols and training for clinical staff working in mental health and other hospital and community health settings;
  - additional mental health assessment and treatment capacity in NSW hospitals, including the establishment of Psychiatric Emergency Care Centres in major metropolitan hospitals and specialist Mental Health Clinical Nurse Consultant positions in Emergency Departments across NSW; and
  - a standardised discharge policy framework to promote continuity of treatment and ongoing support for people leaving adult mental health inpatient settings and their families and carers.
- **NSW Police Force, NSW Health and NSW Ambulance Services** have a responsibility to identify and manage situations involving people at risk of suicide appropriately, with a focus on risk management through:
  - specialised training for paramedics in the assessment and management of suicide risk, including providing immediate support to people affected by suicide;
  - training for police officers to provide immediate support for people affected by suicide;
  - the NSW Police Force's Mental Health Intervention Team program, which includes training to improve awareness by frontline police, and techniques to effectively assist in mental health related incidents and provide strategies to reduce risks to the safety of police, consumers and the community.
- To build wellness and resilience, and encourage help seeking behaviour in **children and young people**, schools:
  - take a universal approach to suicide prevention, embedded through all stages of the Personal Development, Health & Physical Education curriculum;
  - manage risk through initiatives such as School Link, which builds the capacity of schools to identify risk, enhance the expertise of school and TAFE counsellors and mental health workers, and develop local pathways to care; and
  - manage critical incidents and develop emergency plans to deal with the "ripple effects" of suicide.
- Children and young people who have experienced abuse and trauma are at increased risk of suicide and self-harm. To minimise this risk the **child protection system**

focuses on a range of prevention activities through *Keep Them Safe: a shared approach to child wellbeing*.

The five year Action Plan recognises that we need to help families earlier so that they do not escalate into the statutory child protection system including:

- the establishment of a Clinical Issues Unit within Community Services to advise and support staff on complex cases involving mental illness, substance misuse and family/domestic violence issues. Caseworkers will be assisted to identify clients with suicide risk factors and how to refer clients to appropriate local services;
- the development and implementation of resources, tools and other workforce development strategies to assist staff presented with a child or young person who may be at risk of suicide, for example a clinical practice guideline for psychologists.
- strengthening and better linking the response to concerns about the safety, wellbeing and welfare of children through the establishment of Child Wellbeing Units in Departments of Human Services NSW, Education and Training, NSW Health and the NSW Police Force; and
- strengthening and enhancing consistency in child protection reporting by providing an online Mandatory Reporter Guide for frontline workers. The Guide is a resource which helps mandatory reporters determine whether a case meets the new risk of significant harm threshold.

- In addition to wider initiatives to address many of the determinants in **Aboriginal communities** which increase the risk of suicide (at 2.1, above), *Closing the Gap: National Partnership Agreements on Indigenous Health* and *Two Ways Together: the NSW Aboriginal Affairs Plan*, take a preventative approach to improve pathways to health services and ensure those services are culturally appropriate by:
  - encouraging the integration of an holistic approach to health service delivery through the *NSW Aboriginal Mental Health and Wellbeing Policy*;
  - developing a framework for Respectful and Responsive Healthcare Services with Aboriginal individuals, communities and staff, within the *NSW Implementation Plan for the National Partnership Agreement on Closing the Gap In Indigenous Health Outcomes*, to facilitate cultural respect training and guide the health service in the development and delivery of culturally appropriate services across the state;

- through the NSW Aboriginal Mental Health Workforce Program, building a skilled Aboriginal mental health workforce to enable Aboriginal people to care for their own communities;
- developing new programs specific to Aboriginal people at risk of suicide; and
- delivering Aboriginal Mental Health First Aid courses to Aboriginal communities.

- The **criminal justice system** recognises the increased risk of suicide amongst victims of crime. Those who seek emotional assistance from Victims Services are responded to by support workers or counsellors who have training in suicide risk assessment, via business and after hours support services. Where appropriate, this includes consultation with crisis mental health services or by direct referrals to Emergency Departments if the Police or Ambulance are called.
- Offenders face an increased risk of suicide, both because they are imprisoned, and because they are often part of a number of other at risk population groups. Suicide prevention in the **correctional system** is focused on identification and management of suicide risk. All people received into custody are screened for suicide risk in addition to:
  - education for staff in the initial identification and management of people at risk, and a Risk Intervention Team policy for identification, assessment and management of 'at risk' offenders;
  - targeted intervention strategies, with specialist units that assist with the further assessment, treatment and management of offenders with mental health, mental disorder, personality disorder, cognitive impairment, and/or self-harm risk;
  - care extending to the transition to release or parole, when the risk of suicide can be heightened, through the Community Offender Support Program which works to house and support otherwise homeless offenders released from prison and help them to integrate into the community and connect with community and other services as needed; and
  - Connections Clinical Support Workers to assist those under Justice Health care with reintegration into the community through linkage with appropriate community based services.



# A strategic framework for suicide prevention in NSW

## 3.1 Principles

The NSW Suicide Prevention Strategy has adopted the principles of the LIFE Framework. These principles include ambitious goals for the future and represent the values that the NSW Government is striving to fulfil in suicide prevention.

### **The NSW Suicide Prevention Strategy puts the individual at the centre of suicide prevention.**

Suicide prevention initiatives must aim to reduce suicide attempts and the loss of life through suicide by improving individuals', families' and communities' access to support so that no one in crisis or experiencing personal adversity sees suicide as their only option.<sup>156</sup>

- Suicide prevention is a shared responsibility across the community, families and friends, professional groups, and non government and government agencies.
- Suicide prevention activities, both universal and individual interventions should first do no harm. Some activities that aim to protect against suicide have the potential to increase suicide risk amongst vulnerable groups. Activities need to respect the context, health, receptivity and needs of the person who is feeling suicidal.
- Activities should be designed and implemented to target and involve the whole population, specific communities and groups who are known to be at risk of suicide, and individuals at risk.
- Activities need to include access to clinical or professional treatment for those in crisis and support for people who are recovering and getting back into life.
- Activities must be appropriate to the social and cultural needs of the groups or populations being served.
- Information, service and support need to be provided at the right time, when it can best be received, understood and applied.
- Activities need to be located at places and in environments where the target groups are comfortable, and where the activities will reach and be accessible to those who most need them.
- Local suicide prevention activities must be sustainable to ensure continuity and consistency of service.
- Suicide prevention activities should either be, or aim to become, evidence based, outcome focused and independently evaluated.
- Activities need to be sensitive to the broader factors that may influence suicide risk – the many social, environmental, cultural and economic factors that contribute to quality of life and the opportunities life offers – and how these vary across different cultures, interest groups, individuals, families and communities.
- Services for people who are recognised as suicidal should reflect a multi disciplinary approach and aim to provide a safe, secure and caring environment.

## 3.2 The model for suicide prevention

The NSW Suicide Prevention Strategy adopts a population health and whole of community approach to suicide prevention. It uses the LIFE Framework's continuum of suicide prevention activities, which identifies eight overlapping "domains of activity",<sup>157</sup> to address the needs of:

- the broader population;
- specific groups identified as being at risk; and
- people who may be at high risk of suicide.

Figure 3.1: LIFE Framework's continuum of suicide prevention activities<sup>158</sup>

Factor	Target groups	Outcome	Who is involved?
Universal intervention	Activities that apply to everyone (whole populations)	Reducing access to means of suicide, altering media coverage of suicide, providing community education about suicide prevention and creating stronger and more supportive families, schools and communities.	Individuals, families, consumer and carer organisations, multicultural organisations, community based health services, local councils, sporting and recreational clubs, workplaces, media, educational organisations, providers of education and information on drug and alcohol, mental health and suicide prevention, service clubs and pubs.
Selective intervention	For communities and groups potentially at risk	Building awareness, resilience, strength and capacity and an environment that promotes self help and help seeking and provides support.	Individuals, families, consumer and carer organisations, community based health services multicultural organisations, local councils, sporting and recreational clubs, workplaces, media, educational organisations, Divisions of GP, service clubs and pubs.
Indicated intervention	For individuals at high risk	Building awareness, strength, resilience, local understanding, capacity and support; being alert to early signs of risk; and taking action to reduce problems and symptoms.	Individuals, families, consumer and carer organisations, community based health services, multicultural organisations, GPs, police, gerontologists, rehabilitation providers, emergency workers, specialist physicians, sporting and recreational clubs, workplaces, educational organisations, service clubs and pubs.
Symptom identification	When vulnerability and exposure to risk are high	Being alert to signs of high risk, adverse health effects, and potential tipping points; and providing support and care.	GPs, help lines, police, gerontologists, rehabilitation providers, community health services, nurses, emergency workers, specialist physicians, teachers, pharmacists, workplaces family and friends and other gatekeepers.
Early treatment	Finding and accessing early care and support	Providing first point of professional contact; targeted and integrated support and care; and monitoring and ensuring access to further information and care.	GPs, psychologists, nurses, allied mental health professionals, Aboriginal Health Workers, emergency departments, police, gerontologists, emergency workers, specialist physicians, community health services, help lines, crisis teams, school counsellors.
Standard treatment	When specialised care is needed	Providing integrated professional care to manage suicidal behaviours and improve wellbeing as a step in recovery.	Psychiatrists, psychologists, GPs, nurses, allied mental health professionals, Aboriginal Health Workers.
Longer term treatment and support	Preparing for a positive future	Providing ongoing integrated care to consolidate recovery and reduce the risk of adverse health effects.	Psychiatrists, psychologists, GPs, nurses, allied mental health professionals, families, workplaces, local community organisations and clubs, rehabilitation services, Aboriginal Health Workers, help lines.
Ongoing care and support	Getting back into life	Building strength, resilience, and adaptation and coping skills, and an environment that supports self help and help seeking.	GPs, allied mental health professionals, Aboriginal Health Workers, community service providers, families, local community organisations, workplaces and clubs.

Safety Nets for people moving between treatment options, and back into the community. These include:

- community based services to support and foster recovery after discharge from clinical care
- effective client handover practices between services and back into the community; and
- effective cooperation and communication between health professionals, community support services, schools, families, workplaces and community groups.

This chapter sets out the strategic directions of this Strategy with intended outcomes and action that will be taken to achieve those outcomes.

In terms of assessing how well these outcomes are achieved, the key performance measure will be the rate of suicide in NSW as reported by the Australian Bureau of Statistics, in the context of the NSW Government's commitment to further reduce the rate of suicide in this state.

Each year, relevant government agencies will also be required to report on the rates of suicide in institutions and facilities including across the health system, schools, police, corrections, and amongst the emergency response or "first responder" workforce.

In addition, noting the significant and particular impact that mental health, alcohol and the loss of family or other personal relationships can have on suicidal behaviour, the following measures will be used:

- NSW State Plan targets for enhancing mental health outcomes;
- NSW State Plan target for reducing risky drinking;
- NSW Population Health Survey rate of psychological distress and wellbeing in adults, young people and children, as a measure of resilience in the NSW population;
- Interagency Action Plan targets measuring:
  - The percentage (or number) of teaching staff and health workers who have received training under the School Link initiative;
  - Mental Health training indicators for Police, Ambulance and Corrective Services/Juvenile Justice.

In terms of results arising from the strategic directions and actions set out in this chapter, each strategic direction is accompanied by a set of results indicators, which can be summarised as the following:

- better informed Government policy and evidence based decision making including across portfolios not directly involved in suicide prevention;
- more dynamic sharing of information and best practice across the community and service providers to stimulate increased innovation and expertise;
- increased and more effective partnerships and networks across government and across the community with a shared approach to suicide prevention;
- greater community discussion on and participation in suicide prevention action and building resilience;
- better responses to at risk individuals and communities, including culturally relevant responses;
- better understanding of, and approaches to suicide bereavement;
- more responsive workplaces and better targeting of support for at risk workers.



### 3.3 Strategic directions

The following Strategic Directions and outcomes are based on the LIFE framework and consultation with stakeholders. They reflect the spectrum of interventions required for a comprehensive whole of community suicide prevention framework.

Strategic direction	Outcomes
1. Improving the evidence base and understanding of suicide prevention	1.1 Understanding of imminent risk and how best to intervene
	1.2 Understanding of whole of community risk and protective factors, and how best to build resilience of communities and individuals
	1.3 Application and continued development of the evidence base for suicide prevention among high risk populations
	1.4 Improved access to suicide prevention resources and information
2. Building individual resilience and the capacity for self help	2.1 Improved individual resilience and wellbeing
	2.2 An environment that encourages and supports help seeking
3. Improving community awareness, strength, resilience and capacity in suicide prevention	3.1 Improved community strength and resilience
	3.2 Increased community awareness of what is needed to prevent suicide
	3.3 Improved capability to respond at potential tipping points and points of imminent risk
4. Taking a coordinated approach to suicide prevention	4.1 Local services linking effectively so that people experience a seamless service
	4.2 Program and policy coordination and cooperation, through partnerships between governments, government agencies, peak and professional bodies and non government organisations
	4.3 Regionally integrated approaches
	4.4 Streamline NSW Health, Ambulance Service of NSW and NSW Police responses to suicide attempts and suicide
5. Providing targeted suicide prevention activities	5.1 Address hotspots and environmental factors
	5.2 Improved access to a range of support and care for people feeling suicidal
	5.3 Systemic, long term, structural interventions in areas of greatest need
	5.4 Reduced incidence of suicide and suicidal behaviour in the groups at highest risk
	5.5 Improved understanding, skills and capacity of frontline workers, families and carers
6. Implementing standards and quality in suicide prevention	6.1 Improved practice, standards and shared learning
	6.2 Improved capabilities and promotion of sound practice in evaluation
	6.3 Systemic improvements in the quality, quantity, access and response to information about suicide prevention programs and services



### 3.3.1 Strategic direction 1: Improving the evidence base and understanding of suicide prevention

Under Strategic Direction 1, the NSW Government will implement initiatives to enhance:

- Understanding of imminent risk and how best to intervene
- Understanding of whole of community risk and protective factors, and how best to build resilience of communities and individuals
- Application and continued development of the evidence base for suicide prevention among high risk populations
- Improved access to suicide prevention resources and information

#### *What the NSW Government will do*

Outcome 1.1: Improve understanding of imminent risk and how best to intervene

**i. Identify and clarify the link between suicide prevention activities and interventions and their impact on, and relevance to, the incidence of suicidal behaviours.**

- Establish a whole of community advisory committee to provide advice on the development and implementation of suicide prevention policies and programs.
- Regularly review suicide risk assessment and management policies, and evaluate the effectiveness of implementation of these guidelines
- Regularly monitor activities under the Suicide Prevention Implementation Plan based on indicators of effectiveness, program quality and efficiency, and quantity, to assist in maintaining a current and effective Plan, and build a future evidence base for suicide prevention strategies.

**ii. Improve the evidence base for the early identification and management of people at high risk of suicide.**

- Annually review available data on suicide rates in NSW to provide more detailed information about suicide amongst risk groups and inform initiatives and evaluation.

Outcome 1.2: Improve understanding of whole of community risk and protective factors, and how best to build resilience of communities and individuals

**i. Develop a better understanding of the positive and negative impacts of economic, social and environmental influences on suicide and suicidal behaviours.**

- Annually review available data on suicide rates in NSW, to provide more detailed information about suicide across time and different demographic groups.
- Annually review available national and international evidence on suicide to contribute to a better understanding of suicide causes and patterns

**ii. Improve the evidence base for the impact of community capacity and resilience building in the long term prevention of suicide, including in rural and remote communities and/or those adversely affected by climate change or natural disasters.**

- Continue to apply and implement learnings from initiatives such as the NSW Drought Mental Health Assistance Package to improve responses to mental health and suicide risk in rural and remote communities, and those adversely affected by climate change or natural disasters.

**iii. Consider the influence and impact on suicidal behaviours of new technologies/multimedia communication (e.g. media, internet, MySpace, YouTube, chat rooms, instant messaging).**

- Establish a whole of community advisory committee to provide advice on the development and implementation of suicide prevention policies and programs, with special consideration to be given to cyber bullying and the application of education programs in relation to internet use.
- Review the use of innovative technology as a means to enhance linkages between services, promote help seeking, reduce stigma and enhance existing service delivery to at risk groups, where appropriate.

**iv. Improve understanding of the cultural significance of suicide, suicide attempts and self-harm and how they can be prevented across different cultural and at risk groups.**

- Use available data on suicide rates in NSW, and work with partners across at risk groups to develop appropriate responses to different cultural and at risk groups.

**v. Synthesise and strengthen understanding of suicide through incorporation in relevant systematic, longitudinal, multidisciplinary, multisite studies.**

- Use NSW data and evaluation to contribute to national and international studies.

### Outcome 1.3: Application and continued development of the evidence base for suicide prevention among high risk populations

#### i. **Develop and apply the research and evidence of interventions that work for Aboriginal and Torres Strait Islander communities.**

- Use available data on suicide and suicide risk in Aboriginal communities, together with evaluation of and learnings from existing initiatives to improve understanding of the most effective ways to deliver targeted programs.

#### ii. **Apply the evidence base to identify and address the needs of people bereaved by suicide.**

- Review existing guidelines for dealing with bereavement across health and other government agencies, including pathways to care for those affected by suicide and promotion of culturally appropriate services.

#### iii. **Apply the evidence base of interventions to encourage men's help seeking behaviour and emotional openness.**

- Promote and encourage activities to normalise openness and help seeking behaviours, including through building partnerships at a local level.

#### iv. **Reduce access to means of suicide.**

- Develop protocols across government agencies and relevant organisations for the identification of, and development of appropriate responses to suicide hotspots and emerging environmental factors, including through consultative agreements and incident reviews.

### Outcome 1.4: Improved access to suicide prevention resources and information

#### i. **Contribute to a centre for the collection and dissemination of quality information and resources in suicide prevention.**

- Use NSW data and evaluation to contribute to national and international studies.
- Use existing suicide prevention networks, community networks and new e-technologies, including the development of "communities of practice", to link various community health and non health professions and specialists together to share skills and knowledge, and provide improved coordination of responses and local pathways to care.
- Establish annual whole of government and whole of community showcases for innovative approaches to suicide prevention and resilience building.

### Examples of initiatives that will contribute to Strategic Direction 1

#### **What we are already doing**

- **Ongoing review of our policies and approaches**, including ongoing review of suspected suicides and homicides involving mental health patients through the Critical Incident Review Committee; funding for a University Chair in Disability Mental Health, and applying learnings from the NSW Drought Mental Health Assistance Package to improve the evidence base and understanding of effective approaches to suicide prevention.

#### **New initiatives**

- Additional analysis and collection of **NSW data on suicide and attempted suicide**, to improve the evidence base and understanding of effective approaches, through initial analysis of data, and consideration by a whole of community Suicide Prevention Advisory Committee, reporting to the Minister Assisting the Minister for Health (Mental Health) through the NSW Mental Health Priority Taskforce.
- Development of new **performance indicators** through the Suicide Prevention Strategy to better understand the impact of initiatives.
- Approaches to **evaluate and improve application of learnings**, including a review of the NSW Suicide Risk Assessment and Management for NSW Health staff policy, and an evaluation of the effectiveness of its implementation, and annual reporting on implementation of the Suicide Prevention Strategy.

#### How will we know?

- Annually publish data on suicide rates in NSW on an age and geographical basis, and among high risk groups where statistically measurable.
- Rate of young people in custody who have thought about or attempted suicide.
- Number of "hits" on suicide prevention resources website, by access to general and subscribed or professional areas.
- Establishment of the whole of community Suicide Prevention Advisory Committee.

#### Partners

NSW Health, all agencies

### 3.3.2 Strategic direction 2: Building individual resilience and the capacity for self help

Under Strategic Direction 2, the NSW Government will implement initiatives to develop:

- Improved individual resilience and wellbeing
- An environment that encourages and supports help seeking

#### *What the NSW Government will do*

##### Outcome 2.1: Improved individual resilience and wellbeing

###### **i. Develop and promote universal programs that build life skills that enhance individual and community resilience.**

- Continue to develop and implement early childhood and school based programs which promote resilience and support children and young people to help reduce suicide risk.
- Develop partnerships with key community stakeholders and work collaboratively to establish, promote and implement capacity building activities for the community as a whole.

###### **ii. Develop and promote mental health and wellbeing programs for the whole community, including those designed to support particular high risk groups or populations.**

- Connect to and align with other frameworks which work to build mental health in the community, including the *NSW Community Mental Health Strategy*, the *NSW Aboriginal Mental Health and Wellbeing Policy* the *NSW Multicultural Mental Health Plan*, *NSW Health Mental Health and Drug and Alcohol Comorbidity Framework for Action*, and the *NSW Service Plan for Specialist Mental Health Services for Older People*.

###### **iii. Provide support to professions that have a key role in suicide prevention or trauma response, to safeguard mental health and wellbeing, enhance service delivery, improve staff retention and minimise the likelihood of suicide.**

- Develop and build on current partnerships across government and non government agencies and with key professions (including health professionals, law enforcement officers, emergency services personnel, corrective services personnel, education and social service professionals) to offer targeted education and training, including understanding mental illness, suicide risk awareness and management, and support for staff.

###### **iv. Foster environments where it is acceptable to express emotions (anxiety, stress, sadness, grief) without a fear of stigmatisation.**

- Connect to and align with other frameworks and initiatives that work to enhance social and emotional wellbeing, and equip people with the skills to express and understand emotions.
- Continue to develop and implement programs that raise awareness of suicide prevention and people at risk, encourage help seeking behaviour and challenge the stigma associated with suicide.
- Develop whole of government, whole of community guidelines for dealing with and discussing suicide and attempted suicide within families, schools, workplaces and communities.

##### Outcome 2.2: An environment that encourages and supports help seeking

###### **i. Develop and promote programs that raise awareness of the importance of social and emotional wellbeing, mental disorders and suicide prevention.**

- Connect to existing community networks, and in particular those that provide support to high risk groups, building suicide awareness and understanding into their programs.
- Use school, workplace and community settings to deliver programs that identify and encourage discussion of positive mental health to support help seeking.
- Use multimedia resources, new technology and innovative settings to promote mental health and resilience and continue to raise awareness of depression and suicide.

###### **ii. Develop and promote programs to enhance help seeking behaviour among high risk groups and in people that are known to be least likely to seek help.**

- Continue to develop and implement programs targeting high risk groups, such as young people, men (in particular rural and older men), Aboriginal people, GLBT communities, and people from some culturally and linguistically diverse communities, partnering with existing programs for these groups, where appropriate.
- Connect to and align with help seeking mechanisms and approaches established through other frameworks, such as the *NSW Aboriginal Mental Health and Wellbeing Policy* and the *NSW Multicultural Mental Health Plan*.

###### **iii. Work to destigmatise conditions that contribute to suicide risk with a view to encouraging help seeking behaviour.**

- Improve links across government agencies and community groups to improve awareness of and understanding about risk factors for suicide, including mental illness, homelessness, and financial hardship, and provide pathways to appropriate services.

## Examples of initiatives that will contribute to Strategic Direction 2

### What we are already doing

- **Connecting to and aligning with other frameworks** which work to build individual resilience and improved mental health across the whole community, including a range of **at risk groups**: the *NSW Community Mental Health Strategy*, the *NSW Aboriginal Mental Health and Wellbeing Policy*, the *Framework for Respectful and Responsive Healthcare Services with Aboriginal Individuals, Communities and Staff*, the *NSW Health Mental Health, Drug and Alcohol Comorbidity Framework for Action*, the *NSW Multicultural Mental Health Plan*, the *Specialist Mental Health Services for Older People Service Plan* and *Keep Them Safe* reforms.
- Initiatives that target different **life stages**, including Families NSW initiatives for families expecting a baby or with young children such as the Triple P Parenting Program, Safe Start and Schools as Community Centres, programs for Children of Parents with Mental Illness, evidence based depression prevention programs for children and adolescents, youth mental health services, Elderly Suicide Prevention Networks, and Specialist Mental Health Services for Older People.
- Initiatives delivered through the **education system**, including those which provide support at transition points, such as School Link, Supporting Students in the HSC years, school and TAFE counselling programs, the Access Employment, Education & Training Framework.
- Initiatives to target particular **at risk groups**, including:
  - for **Aboriginal people**: Aboriginal Maternal & Infant Health Services, Building Strong Foundations for Aboriginal Children, Families & Communities, Aboriginal Workforce Training (grief and loss), Aboriginal Mental Health Trainees, Koori Outreach Options for Learning
  - screening and self referral to psychologists and counsellors at **Juvenile Justice Centres**
  - the Drought Mental Health Assistance Package, for **rural communities**
  - to support **older people**, the NSW Health Suicide Prevention for Older People training manual

### New initiatives

- **Community based initiatives**, such as expansion of Community Drug Action Teams, and the development of new guidelines for discussing suicide in schools, workplaces, communities and families.
- Initiatives to provide training and support in the **workplace**, including Mental Health First Aid (MHFA) training, the Workplace Health Promotion Network, specialised MHFA training for professions which play a key role in suicide prevention or trauma response, and the State Mental Health Telephone Access Line.
- Initiatives to target particular **at risk groups**, including working with ACON to develop a strategy to address risk amongst **GLBT** people, distribution of information under the Homelessness Action Plan about risk factors for **homelessness** and available services, and training for **health staff** to recognise and manage suicide in patients and colleagues, and develop resiliency in the individual.

### How will we know?

- Proportion of adults with high or very high levels of psychological distress.
- Rate of students who sought help when feeling unhappy, sad, or depressed.

### Partners

NSW Health, NSW Department of Education & Training, TAFE NSW, NSW Department of Community Services, NSW Department of Juvenile Justice, NSW Department of Ageing, Disability and Home Care, all agencies

### 3.3.3 Strategic direction 3: Improving community awareness, strength, resilience and capacity in suicide prevention

Under Strategic Direction 3, the NSW Government will implement initiatives to develop:

- Improved community, strength and resilience
- Increased community awareness of what is needed to prevent suicide
- Improved capability to respond at potential tipping points and points of imminent risk

#### *What the NSW Government will do*

##### Outcome 3.1: Improved community strength and resilience

###### **i. Raise awareness of the characteristics of healthy and resilient communities and support their development.**

- Develop partnerships with key community stakeholders and networks and work collaboratively to raise awareness of the characteristics of healthy and resilient communities, including increased linkages between good mental and physical health, and with a particular focus on at risk groups.
- Continue to develop and implement programs across life stages and at risk groups that encourage and build healthy and resilient communities, reduce social isolation, and maintain social and family engagement and cultural identity.

###### **ii. Use mentoring and leadership development programs to promote the development and sharing of good practice in local communities.**

- Continue to resource and support local community groups to run skill development building workshops and activities to build social cohesion and cultural awareness.
- Establish annual whole of government and whole of community showcases for innovative approaches to suicide prevention and resilience building.

###### **iii. Develop and promote strategies that enable and support groups within local communities to work together on suicide prevention.**

- Use existing suicide prevention networks, community networks and new e-technologies, including the development of “communities of practice”, to link various community health and non health professions and specialists together to share skills and knowledge, and provide improved coordination of responses and local pathways to care.

##### Outcome 3.2: Increased community awareness of what is needed to prevent suicide

###### **i. Educate communities to identify and respond to warning signs, tipping points and imminent risk factors associated with suicide.**

- Continue to develop and implement programs that raise awareness of suicide prevention and at risk people, encourage help seeking behaviour and challenge stigma associated with suicide.
- Conduct a social marketing campaign to raise awareness of suicide prevention and people at risk, encourage help seeking behaviour and challenge the stigma associated with suicide.

###### **ii. Work with mainstream and multilingual media to improve community understanding of suicide and suicide prevention and encourage responsible coverage of these issues.**

- Develop whole of government, whole of community culturally appropriate guidelines for dealing with and discussing suicide and attempted suicide within families, schools, workplaces and communities, including how to respond to reports in the media.

###### **iii. Reduce the stigma and myths surrounding suicide by actively communicating the range and complexity of factors that contribute to suicidal behaviours.**

- Develop and build partnerships across government agencies, the education system, and community and business groups to encourage active communication of factors that contribute to suicidal behaviour through mental health education.

###### **iv. Develop and promote strategies that enable organisations to work together to reduce risk factors and strengthen protective factors in individuals and communities.**

- Continue to implement and champion the work of suicide prevention networks and other community groups, and develop and promote strategies that reduce risk factors and strengthen protective factors in individuals and communities.
- Connect to existing community networks and in particular those that provide support to high risk groups, as environments for discussion and raising awareness.

### Outcome 3.3: Improved capability to respond at potential tipping points and points of imminent risk

#### i. Enable locally based networks and cooperative partnerships to respond effectively to traumatic incidents or significant changes in local circumstances (e.g. drought, industry closures).

- Continue to implement initiatives that enhance community awareness of and capacity to respond to traumatic incidents and significant changes in local circumstances, including identifying emerging needs, improving early intervention strategies and pathways to care, reducing stigma and strengthening the role of General Practitioners in networks and services.

#### ii. Develop materials and provide locally based support to assist staff and volunteers in organisations such as pubs, clubs, cultural and religious centres and recreational and sporting groups, to identify potential suicidal behaviour and to respond effectively.

- Connect to existing community and suicide prevention networks to promote new pathways to discussion and awareness raising, including through the promotion of appropriate skills training.

#### iii. Expand and resource the capacity of schools, workplaces and other relevant settings, to identify and support those at risk.

- Continue to develop and implement risk assessment frameworks to identify and provide pathways to care and support for those at risk across a variety of community settings, including through education, health, emergency, social, criminal justice, corrective and other relevant services.
- Work across government agencies and community groups to improve understanding about risk factors and pathways to care.

#### iv. Use media and other strategies to raise awareness of the risk factors, warning signs and tipping points for suicide.

- Develop whole of government, whole of community guidelines for dealing with and discussing suicide and attempted suicide within families, schools, workplaces and communities.

### Examples of initiatives that will contribute to Strategic Direction 3

#### What we are already doing

- Initiatives that target different **life stages**, including Families NSW initiatives for families expecting a baby or with young children such as the Triple P Parenting Program, Safe Start and Schools as Community Centres, evidence based depression prevention programs for children and adolescents, youth mental health services, Elderly Suicide Prevention Networks, and Specialist Mental Health Services for Older People Active & Health Groups.
- Initiatives delivered through the **education system**, including those that provide support at transition points, such as School Link, mental health discussion as part of the Personal Development, Health and Physical Education syllabus, Supporting Students in the HSC years, school and TAFE counselling programs, resources in mental health and drugs and alcohol and health promotion for TAFE students and staff, and the Access Employment, Education & Training Framework.
- Initiatives delivered through the **Corrective Services system**, including risk management approaches for offenders at key points including entry to custody and at the time of court and sentencing events, pre-release planning, and special units that assist with the further assessment, treatment and management of offenders in custody with mental health, mental disorder, personality disorder, cognitive impairment, and/or self-harm risk.

#### New initiatives

- **Community based initiatives**, such as suicide prevention networks, the expansion of Community Drug Action Teams, including involvement in local events to promote awareness, and the development of communities of practice to link various community health and non health professions and specialists; and, targeted at **specific communities**, the Drought Mental Health Assistance Program, Farm-Link and Community Action Plans in Aboriginal communities under the Partnership Community Program.
- **Media focused initiatives**, including new guidelines for discussing suicide and a social marketing campaign to raise awareness of suicide prevention and people at risk, encourage help seeking behaviour and challenge the stigma associated with suicide.
- Initiatives to provide training and support in the **workplace**, including Mental Health First Aid training.

#### How will we know?

- Number of wellbeing focused Community Drug Action Team initiatives.
- Release of community suicide prevention resources.
- Rate of participation in the arts, sport and recreation.
- Number of referrals to the Employee Assistance Program.
- Number of self-harm incidents in custody.

#### **Workforce training:**

- Number of people who have received workforce mental health awareness training.
- Rate of school counsellors managing mental health issues.
- Percentage of frontline police officers accredited as specialist Mental Health Intervention officers.
- Relevant indicators for success of the Justice Health Community Integration and Connections Teams.
- Number of Corrective Services NSW staff participating in training including refresher training for Suicide Awareness and Mental Health First Aid.

#### Partners

NSW Health, NSW Department of Education & Training, TAFE NSW, NSW Department of Community Services, NSW Police Force, all agencies.



### 3.3.4 Strategic direction 4: Taking a coordinated approach to suicide prevention

Under Strategic Direction 4, the NSW Government will implement initiatives to develop:

- Local services linking effectively so that people experience a seamless service
- Program and policy coordination and cooperation, through partnerships between governments, peak and professional bodies and non government organisations
- Regionally integrated approaches
- Streamline NSW Health, Ambulance Service of NSW and NSW Police responses to suicide attempts and suicide

#### *What the NSW Government will do*

**Outcome 4.1: Local services linking effectively so that people experience a seamless service**

**i. Encourage and promote integrated, cross functional, cross agency solutions to locally based suicide prevention activities.**

- Use existing suicide prevention networks, community networks and new e-technologies, including the development of “communities of practice”, to link various community health and non health professions and specialists together to share skills and knowledge, and provide improved coordination of responses and local pathways to care.

**ii. Continue to support and promote pathways to care to enable people to access services and inform and improve service responses.**

- Develop and build on partnerships across government agencies and with key professions at a local level, including through the use of common language across fields, memorandums of understanding, awareness training and the use of diagnosis and referral tools to increase service access and effectiveness.
- Continue to roll out new ways to access specialised emergency mental health services at a local level for general health workers, to improve immediate handling of people at risk.

**iii. Develop and promote client centred, shared case management approaches to suicide prevention in local communities.**

- Continue to develop and implement cross agency client centred initiatives, including improved assessment practices with a particular focus on at risk groups.

**iv. Strengthen the capacity for families, schools, workplaces, pubs, clubs and sports, recreational and social groups to identify quickly and respond effectively to indicators of potential suicidal behaviour.**

- Work across government agencies and community groups to improve understanding about risk factors and pathways to care.
- Continue to develop and implement early childhood and school based programs that promote resilience and support children and young people to help reduce suicide risk.
- Conduct a social marketing campaign to raise awareness of suicide prevention and people at risk, encourage help seeking behaviour and challenge the stigma associated with suicide.
- Develop whole of government, whole of community culturally appropriate guidelines for dealing with and discussing suicide and attempted suicide within families, schools, workplaces and communities.
- Develop and build partnerships across government agencies, the education system, and community and business groups to encourage active communication of factors that contribute to suicidal behaviour through mental health education.
- Continue to implement initiatives to enhance community awareness of and capacity to respond to traumatic incidents and significant changes in local circumstances, including identifying emerging needs, improving early intervention strategies and pathways to care, reducing stigma and strengthening the role of General Practitioners in networks and services.

**v. Develop practical tools for information sharing, including shared service agreements, dealing with privacy and confidentiality requirements and barriers, developing local data and outcome measures, and joint service/client protocols.**

- Continue to develop and implement cross government service agreements to improve identification of people at risk and facilitate pathways to care.
- Promote and support joint care plans, case conference and collaborative working arrangement, including sharing of risk assessment and care plans.

**vi Promote and support linkages between community based and clinical initiatives in suicide prevention.**

- Continue to develop and implement risk assessment frameworks to identify and provide pathways to care and support for those at risk across a variety of community settings, including through education, health, emergency, social, criminal justice, corrective and other relevant services.
- Use existing suicide prevention networks, community networks and new e-technologies, including the development of “communities of practice”, to link various community health and non health professions and specialists together to share skills and knowledge, and provide improved coordination of responses and local pathways to care.

Outcome 4.2: Program and policy coordination and cooperation, through partnerships between governments, government agencies, peak and professional bodies and non government organisations

**i. Develop cross government mechanisms to improve the integration of health, housing, community, justice, employment and other policy and programs, for better suicide prevention.**

- Develop and promote innovative new cross government responses to issues affecting at risk groups, including training for relevant workers to identify risk factors, improved pathways to care, and cross agency collaboration, focused in particular on at risk groups, including those experiencing significant change in their lives.

**ii. Support and improve linkages and cooperation between governments, academic institutions, non government organisations (NGOs), peak and professional bodies, to support information sharing and reduce duplication of effort.**

- Use existing suicide prevention networks, community networks and new e-technologies, including the development of “communities of practice”, to link various community health and non health professions and specialists together to share skills and knowledge, and provide improved coordination of responses and local pathways to care.

**iii. Design and implement resources and tools (e.g. shared care guidelines, protocols and evaluation tools for professionals, multidisciplinary teams and service providers) to support coordinated community service provision.**

- Continue to implement appropriate risk management training and guidance for relevant staff across the health system, and within other relevant human services agencies, including adapted assessment tools for particular needs, such as youth services, other health services and social services.

**iv. Address the information needs of different professional and community groups concerned with suicide prevention.**

- Use existing suicide prevention networks, community networks and new e-technologies, including the development of “communities of practice”, to link various community health and non health professions and specialists together to share skills and knowledge, and provide improved coordination of responses and local pathways to care.

Outcome 4.3: Regionally integrated approaches

**i. Actively engage local government in suicide prevention.**

- Work with local councils in the development and implementation of their Community Strategic Plans and Delivery Programs to incorporate the approach of, and actions under the Suicide Prevention Strategy wherever possible.

**ii. Strengthen local capacity, particularly in rural, remote and regional areas by supporting and sharing of practice and experience across agencies involved in community and emergency services.**

- Continue to implement initiatives to enhance local community capacity in rural areas, including by using existing suicide prevention networks, community networks and new e-technologies, and identifying emerging needs, improving early intervention strategies and pathways to care, reducing stigma and strengthening the role of General Practitioners in networks and services.

**iii. Develop shared service agreements, local data and service metrics, joint service protocols and joint client assessments.**

- Work across government agencies to deliver appropriate responses to local issues, including locally relevant risk factors, hotspots, and access to means of suicide.

Outcome 4.4: Streamline NSW Health, Ambulance Service of NSW and NSW Police responses to suicide attempts and suicide

**i. Work through the NSW Inter Departmental Committee for Mental Health to improve NSW Health, Ambulance Service of NSW and NSW Police response to emergency mental health events.**

- Reflect the NSW Suicide Prevention Strategy in the reviewed Memorandum of Understanding – Mental Health Emergency Response.
- Include the NSW Suicide Prevention Strategy as a standing agenda item for the NSW Inter Departmental Committee for Mental Health.

## Examples of initiatives that will contribute to Strategic Direction 4

### What we are already doing

- Improved **emergency responses**, including Psychiatric Emergency Care Centres, the Rural Mental Health Emergency Care Program, and the Community Mental Health Emergency Care Program.
- Improved **coordination of emergency responses**, through the NSW Inter Departmental Committee for Mental Health, including its oversight of the NSW network of Mental Health Local Protocol Committees which have membership from local Emergency Departments, Mental Health Services, NSW Police and Ambulance.
- **Tools and practices** to improve identification of those at risk and enable better pathways to care, including the Framework for Suicide Risk Assessment and Management for NSW Health staff, the NSW Health Suicide Prevention for Older People training manual, the Youth Mental Health Services Model, the Rural Mental Health Emergency & Critical Care program, School Link, HealthOne NSW, the Dual Diagnosis Support Kit, and the Housing & Accommodation Support Initiative.
- The Drought Mental Health Assistance Package and Farm-Link project officers, for **rural communities**.

### New initiatives

- **Community based initiatives**, such as suicide prevention networks, the expansion of Community Drug Action Teams, including involvement in local events to promote awareness, and the development of communities of practice to link various community health and non health professions and specialists, and the Drought Mental Health Assistance Program.
- Improved **emergency responses**, including the Statewide 24 hour Mental Health Access Line.
- **Tools and practices** to improve identification of those at risks and enable better pathways to care, including Mental Health First Aid (MHFA) training, risk assessment training for non mental health specialists, a common assessment tool for services working with homeless people to identify their support and accommodation requirements, tools and referral pathways under Keep Them Safe, Changes through the Keep Them Safe reform relating to Information Exchange through the Children and Young Persons (Care and Protection) Act 1998, a future Ageing Disability & Home Care/Health Memorandum of Understanding to facilitate greater coordination of services to increase service access and effectiveness, and a cross government initiative to reduce the risk and incidence of suicide on the rail system.
- Improved case management within **Juvenile Justice** Centres and Justice Health Community Integration Teams for high risk detainees leaving Juvenile Justice's custody.

### How will we know?

- Number of referrals to mental health and drug & alcohol services from GPs and other community programs.
- Number of "hits" on suicide prevention resources website, by access to general and subscribed or professional areas.
- Number of referrals to the Employee Assistance Program.
- NSW Suicide Prevention Strategy reflected in the reviewed Memorandum of Understanding for Mental Health Emergency Response.
- NSW Suicide Prevention Strategy to be added as a standing agenda item for the NSW Inter Departmental Committee for Mental Health.
- Establishment of the whole of community Suicide Prevention Advisory Committee.

### Partners

NSW Health, Ambulance Service of NSW, Justice Health, NSW Department of Education & Training, Aboriginal Affairs NSW, NSW Department of Ageing Disability & Home Care, NSW Department of Community Services, NSW Department of Juvenile Justice, NSW Police Force, NSW Transport & Infrastructure, RailCorp, Roads & Traffic Authority of NSW



### 3.3.5 Strategic direction 5: Providing targeted suicide prevention activities

Under Strategic Direction 5, the NSW Government will implement initiatives to develop:

- Improved responsiveness to hotspots and environmental factors
- Improved access to a range of support and care for people feeling suicidal
- Systematic, long term, structural interventions in areas of greatest need
- Reduced incidence of suicide and suicidal behaviour in the groups of highest risk
- Improved understanding, skills and capacity of frontline workers, families and carers

#### *What the NSW Government will do*

##### Outcome 5.1: Improved responsiveness to hotspots and environmental factors

###### **i. Develop mechanisms for early identification of, and responses to suicide hotspots and environmental factors.**

- Develop protocols across government agencies and relevant organisations for the identification of, and development of appropriate responses to suicide hotspots and emerging environmental factors, including through consultative agreements and incident reviews.
- Develop whole of government, whole of community guidelines for dealing with and discussing suicide and attempted suicide within families, schools, workplaces and communities.

###### **ii. Develop strategies and services to address hotspots and environmental factors.**

- Work across government agencies and relevant organisations to develop appropriate responses and pathways to care, particularly for at risk groups, for those at transition points in life, and in situations where access to means of suicide is increased.

##### Outcome 5.2: Improved access to a range of support and care for people feeling suicidal

###### **i. Contribute to the development of and promotion of innovative programs to reach those in high risk populations who traditionally do not access health services.**

- Continue to develop and implement outreach programs targeting high risk groups who traditionally do not access health services, including linking with other programs and community settings, and by developing partnerships with organisations in contact with those populations.

###### **ii. Make services highly visible and approachable.**

- Connect to existing community networks, and in particular those that provide support to high risk groups, to improve pathways to help and to provide ongoing support.

###### **iii. Support people with mental illness and related problems who are at risk of suicide.**

- Use evidence based intervention across a range of settings to identify people with mental illness and related problems who are at risk of suicide as early as possible.
- Work across government to facilitate greater coordination of services, to increase service access and effectiveness, and help people with a mental illness improve their quality of life and participate in the community, increasing resilience and avoiding the risk of readmission to inpatient care.

###### **iv. Improve bereavement counselling and support services for people affected by suicide.**

- Continue to distribute resources to support those affected by suicide, including information on dealing with grief and loss, contact numbers for community support groups and information on what happens after a suicide death.
- Work across government to provide appropriate bereavement counselling and support services in communities which may be particularly affected by suicide, including schools, workplaces, families and among Aboriginal communities.

##### Outcome 5.3: Systematic, long term, structural interventions in areas of greatest need

###### **i. Identify communities in which suicide and suicidal behaviour is prevalent, and proactively develop strategies and services that address the underlying causes and contributing factors.**

- Continue to implement initiatives to enhance local community capacity in at risk areas, including rural areas and Aboriginal communities, identifying emerging needs, improving early intervention strategies and pathways to care, reducing stigma and strengthening the role of General Practitioners in networks and services.
- Work across government agencies to share knowledge and build resilience and opportunity among at risk groups, including through education and training, and community networks.

###### **ii. Provide and resource mentoring and support for high risk groups and communities, to enable them to undertake effective suicide prevention activities.**

- Develop resources and support structures for at risk groups, including through community networks and self help programs.

#### Outcome 5.4: Reduced incidence of suicide and suicidal behaviour in the groups of highest risk

**i. Support interventions for groups identified as high risk. This includes men aged 20-54 and over 75, men in Aboriginal and Torres Strait Islander communities, people with a mental illness, people with substance use problems, people in contact with the justice system, people who attempt suicide, people in rural and remote communities, gay, lesbian, bisexual and transgender community, people from some culturally and linguistically diverse communities, and people bereaved by suicide.**

- Continue to develop and implement cross agency client centred initiatives, including improved assessment practices with a particular focus on at risk groups.
- Work across the community with non government organisations to develop and promote specific suicide prevention programs for at risk groups.

**ii. Develop effective and sustainable interventions for groups and communities where suicidal behaviours are prevalent, by encouraging ownership and active involvement.**

- Continue to implement and champion the work of suicide prevention networks and other community groups to develop and promote strategies that reduce risk factors and strengthen protective factors in individuals and communities.

**iii. Develop and promote mental health and wellbeing programs in occupational groups whose members are subject to frequent traumatic events (e.g. Police, Paramedics, Emergency Services).**

- Develop and build on current partnerships across government and non government agencies and with key professions (including health professionals, law enforcement officers, emergency services personnel, education and social service professionals) to offer targeted education and training, including understanding mental illness, suicide risk awareness and management, and support for staff.
- Continue to provide immediate response, support and counselling services across relevant government agencies, including Police, Paramedics, Emergency Services and Correctional Services.

**iv. Provide support to the caring professions to minimise the likelihood of suicide among carers and clinical professionals.**

- Continue to provide and strengthen clinical support and employee assistance for clinical professionals and those providing mental health services in other relevant settings.
- Provide funding to non government organisations and Area Mental Health Services for the education, support and participation of families and carers, to improve outcomes for people with a mental illness and improve the wellbeing of families and carers, including improved health and quality of life, reduced distress and isolation, improved family relationships, and greater access to services.
- Follow up with the Coroner's Court about their provision of bereavement counselling services to families affected by suicide. NSW Police Force officers are instructed to give referral information to the Coroner's counselling services when assisting family at a completed suicide.

## Outcome 5.5: Improved understanding, skills and capacity of frontline workers, families and carers

### **i. Improve procedures for the immediate management of suicide.**

- Work across government agencies and community groups to improve the understanding, skills and capacity of frontline workers, including clinical professionals, Emergency Services, and families and carers to respond to suicide, including improving pathways to care and support.
- Regularly review practice following Root Cause Analyses to identify, respond to and improve procedures.

### **ii. Implement guidelines and support tools to improve the understanding and skills of frontline workers who routinely interact with high risk groups, to identify and respond rapidly to suicide warning signs, tipping points and imminent risk factors.**

- Continue to implement relevant guidelines and training for frontline workers (including clinical staff, Emergency Services, and those working with other high risk groups) to identify and manage suicide risk and facilitate pathways to appropriate care.

### **iii. Provide education and information for consumers and carers involved with at risk individuals and groups to enable them to identify and respond rapidly to suicidal behaviour.**

- Provide funding to non government organisations and Area Mental Health Services for the education, support and participation of families and carers, to improve outcomes for people with a mental illness and improve the wellbeing of families and carers, including improved health and quality of life, reduced distress and isolation, improved family relationships, and greater access to services.

### **iv. Develop and resource discharge planning, clinical handover and transition to community care and support that recognises the increased risk to individuals at and after discharge.**

- Work across government agencies to facilitate greater coordination of services at transition points, including intensive case management for high need individuals where appropriate.

### **v. Educate and inform professionals, service providers, families and community organisations in the provision of safe and secure care environments for people at risk.**

- Connect to existing professional and community networks, and in particular those that provide support to high risk groups, building suicide awareness and understanding into their programs, including targeted education and training, understanding mental illness, suicide risk awareness and management, and support for staff, where appropriate.

### **vi. Provide access to training programs at undergraduate, post graduate and vocational levels. Wherever possible, these should be multidisciplinary and cross agency.**

- Develop and build on current partnerships across government and non government agencies and with key professions (including health professionals, law enforcement officers, emergency services personnel, education and social service professionals) to offer targeted education and training, including understanding mental illness, suicide risk awareness and management, and support for staff.

## Examples of initiatives that will contribute to Strategic Direction 5

### **What we are already doing**

- Initiatives to **improve understanding of, and respond to suicide risk factors**, including the ongoing review of suspected suicides and homicides involving mental health patients through the Critical Incident Review Committee, and community of practices to share information and experience at a local level.
- Initiatives to **support clinicians and other frontline workers** to respond to people at high risk of suicide, including the Framework for Suicide Risk Assessment and Management for NSW Health staff, Youth Mental Health Services Model, Elderly Suicide Prevention workers, ongoing Mental Health First Aid and suicide awareness training for Corrective Services staff and implementation of the At Risk Strategy in all NSW correctional centres to support co-operation between custodial, non custodial and Justice Health staff.

## Examples of initiatives that will contribute to Strategic Direction 5

### New initiatives

- Responses to **hotspots and environmental factors**, including a cross government initiative to reduce the risk and incidence of suicide on the rail system, and cross agency consultation protocols to improve early identification of, and responses to access to means of suicide.
- Initiatives to assist in reaching out to and supporting people in **at risk groups**, including Aboriginal Workforce Training, the Safe Families Program for Aboriginal communities, Health/Community Services partnership arrangements in relation to services for children and adolescents in out-of-homecare community networks, and managed programs for at risk groups transitioning to community settings, such as Circle Sentencing, Justice Health Community Integration Teams for high risk detainees leaving Juvenile Justice's custody.
- Initiatives to **support clinicians and other frontline workers** to respond to people at high risk of suicide, Mental Health First Aid (MHFA) training, risk assessment training for non mental health specialists, a review of the Discharge Planning Policy for Adult Mental Health Inpatient Services, TAFE NSW qualifications in mental health and drug and alcohol and training for health staff to recognise and manage suicide in patients and colleagues, including through training and education curricula.

### How will we know?

- Cross government consultation on action to be taken on access to means of suicide and environmental factors.
- Number of referrals to mental health and drug & alcohol services from GPs and other community programs.
- Rate of students who sought help when feeling unhappy, sad, or depressed.
- Annually published data on suicide rates in NSW on an age and geographical basis, and among high risk groups where statistically measurable.

### Workforce training:

- Number of people who have received workforce mental health awareness training
- Relevant indicators for success of the Justice Health Community Integration and Connections Teams
- Rate of school counsellors managing mental health issues
- Percentage of frontline police officers accredited as specialist Mental Health Intervention officers
- Number of referrals to the Employee Assistance Program
- Development of Mental Health resources for use by all TAFE NSW staff
- Development of interactive teaching and learning resources to support the delivery of CHC08 Community Services Training Package mental health units of competency

### Partners

NSW Health, Ambulance Service of NSW, Justice Health, NSW Department of Education & Training, Corrective Services NSW, NSW Department of Human Services, NSW Police, Transport NSW, other stakeholders

### 3.3.6 Strategic direction 6: Implementing standards and quality in suicide prevention

Under Strategic Direction 6, the NSW Government will implement initiatives to develop:

- Improved practice, standards and shared learning
- Improved capabilities and promotion of sound practice in evaluation
- Systematic improvements in the quality, quantity, access and response to information about suicide prevention programs and services

#### *What the NSW Government will do*

##### Outcome 6.1: Improved practice, standards and shared learning

###### **i. Promote national standards specific to suicide prevention.**

- Establish a whole of community advisory committee to provide advice on the development and implementation of suicide prevention policies and programs.

###### **ii. Disseminate evidence to underpin practice.**

- Use existing suicide prevention networks, community networks and new e-technologies, including the development of “communities of practice”, to link various community health and non health professions and specialists together to share skills and knowledge, and disseminate evidence.

###### **iii. Identify the skills and training required to work effectively in suicide prevention.**

- Implement regular assessment for health staff against suicide risk assessment and management competencies.

##### Outcome 6.2: Improved capabilities and promotion of sound practice in evaluation

###### **i. Promote systematic evaluation of suicide prevention initiatives.**

- Regularly review suicide risk assessment and management policies, and evaluate the effectiveness of implementation of these guidelines.

###### **ii. Promote the role of evaluation and research in expanding the evidence base of suicide prevention and assist in continuously improving practices.**

- Use networks across government agencies, non government organisations, academic and community networks, and through e-technologies, to promote evaluation methods and results and communicate new approaches to suicide prevention.

###### **iii. Develop and promote robust and accountable evaluation models and processes.**

- Commission and publish an independent evaluation of the Strategy linked to key performance indicators, to provide the basis for future suicide prevention strategies in NSW.

###### **iv. Improve the capacity to undertake sound evaluations.**

- Regularly monitor activities under the Suicide Prevention Implementation Plan based on indicators of effectiveness, program quality and efficiency, and quantity, to assist in maintaining a current and effective Plan, and build a future evidence base for suicide prevention strategies.

##### Outcome 6.3: Systematic improvements in the quality, quantity, access and response to information about suicide prevention programs and services

###### **i. Develop and maintain timely, robust and transparent reporting systems to ensure that information on suicide prevention programs is available.**

- Review implementation of the Strategy quarterly through cross government meetings of the Senior Officers’ Group on Mental Health.
- Report to Cabinet annually on the implementation of the Strategy through progress reports to the Justice and Human Services Chief Executive Officers’ Cluster and the Minister Assisting the Minister for Health (Mental Health).
- Report to the Australian Health Ministers’ Conference annually on progress against each of the Strategic Directions, with this information ultimately reported to COAG.

###### **ii. Enable access to information about suicide prevention programs, so that new programs can build on past experience.**

- Use existing suicide prevention networks, community networks and new e-technologies, including the development of “communities of practice”, to link various community health and non health professions and specialists together to share skills and knowledge, and disseminate evidence.

### iii. Encourage and support shared learnings to reduce duplication and promote good practice.

- Establish a whole of community advisory committee to provide advice on the development and implementation of suicide prevention policies and programs.
- Establish annual whole of government and whole of community showcases for innovative approaches to suicide prevention and resilience building.

### Examples of initiatives that will contribute to Strategic Direction 6

#### What we are already doing

- **Ongoing review of our policies and approaches**, including ongoing review of suspected suicides and homicides involving mental health patients through the Critical Incident Review Committee, and funding for a University Chair in Disability Mental Health.

#### New initiatives

- **Networks** to analyse, promote and disseminate best practice, standards, and evaluation of suicide prevention initiatives, including a whole of community Suicide Prevention Advisory Committee, reporting to the Minister Assisting the Minister for Health (Mental Health) through the NSW Mental Health Priority Taskforce; the cross government Senior Officers' Group on Mental Health, reporting to the Justice and Human Services Chief Executive Officers' Cluster; suicide prevention; and suicide prevention networks and communities of practice to link various community health and non health professions and specialists and annual showcases to promote and link innovative approaches to suicide prevention.
- **Evaluate and improve application of learnings**, including a review of the NSW Suicide Risk Assessment and Management for NSW Health staff policy, and an evaluation of the effectiveness of its implementation, and annual reporting on implementation of the Suicide Prevention Strategy.

#### How will we know?

- Publication of an evaluation framework for the Suicide Prevention Strategy.
- Annual whole of government and whole of community showcases for innovative approaches to suicide prevention and resilience building.
- Establishment of the whole of community Suicide Prevention Advisory Committee.

#### Partners

NSW Health, NSW Department of Ageing Disability & Home Care, all agencies

# Implementation and evaluation

## 4.1 Governance

The complex nature of suicide requires a collaborative approach to suicide prevention, coordinated across government agencies and integrated with the community and non government sectors.

NSW Health will lead and coordinate implementation across government agencies through the Senior Officers' Group on Mental Health, which reports to the Justice and Human Services Chief Executive Officers' Cluster.

This approach will be complemented by the establishment of a whole of community Suicide Prevention Advisory Committee, reporting to the Minister Assisting the Minister for Health (Mental Health) through the NSW Mental Health Priority Taskforce.

The Advisory Committee will include representatives from government agencies, the non government sector, academia, business sector, and community and carer organisations.

The Advisory Committee will collaborate with the Senior Officers' Group on Mental Health and provide advice on policy issues and partnerships between the Government, non government and community sectors, research bodies, and businesses, in the development and delivery of suicide prevention policies and programs.

## 4.2 Implementation

NSW Health will coordinate the development of a dynamic whole of government Implementation Plan. This Plan will specify:

- the activities to be undertaken for each Strategic Direction;
- which government agency will lead these activities and which will be partner agencies; and
- timeframes for implementation.

All activities in the Implementation Plan will be specific,

measurable, attainable, realistic and timely, with a focus on practical initiatives that can be undertaken at the State level.

Although the Strategy and Implementation Plan refer specifically to the Strategic Directions and actions of government agencies, suicide prevention must be viewed as a whole of community or whole of society issue. This imperative has been addressed through extensive consultation with academics, the non government sector, and community and carer organisations in the development of the Strategy and their demonstrated commitment to its success.

## 4.3 Monitoring and reporting

The NSW Government will continually monitor the implementation of the Strategy to ensure that commitment to initiatives is maintained. This monitoring will also assist in the process of review and evaluation.

Monitoring and reporting will occur in the following ways:

- implementation of the Strategy will be considered at quarterly meetings of the Senior Officers' Group on Mental Health;
- annual progress reports on the implementation of the Strategy will be provided to Cabinet through the Justice and Human Services Chief Executive Officers' Cluster and the Minister Assisting the Minister for Health (Mental Health); and
- progress against each of the Strategic Directions will also be reported annually to the Australian Health Ministers' Conference as required under the National Mental Health Plan, with this information ultimately reported to the Council of Australian Governments.

## 4.4 Review and evaluation

Appropriate monitoring and evaluation processes for the NSW Suicide Prevention Strategy are essential to ensure accountability and the quality, appropriateness and effectiveness of initiatives.

The development of an Implementation Plan allows, through the monitoring process described above, for the continual review of initiatives under each Strategic Direction including their appropriateness and effectiveness in light of emerging evidence.

Continual review also allows for the inclusion of new activities under the Implementation Plan and the rollout of successful pilot programs across the state, where appropriate.

Supplementary to annual progress reports, an independent evaluation of the five year Strategy linked to key performance indicators will be carried out on its completion. This will be coordinated by NSW Health, with contributions required from all responsible Government agencies and project partners. This evaluation will be provided to Cabinet and made publically available; providing the basis for future suicide prevention strategies in NSW.

The NSW Government also acknowledges the limited evidence of what is effective in suicide prevention, and the challenges of evaluating the effects of suicide prevention programs. Therefore, it is important that all initiatives included in the Strategy are systematically evaluated to allow NSW to contribute to the evidence base for suicide prevention activities.

As outlined in the national LIFE framework, evaluations of suicide prevention activities may include indicators of:

- effectiveness;
- program quality;
- efficiency; and
- quantity.

# Current suicide prevention initiatives

- Families NSW is a whole of government population, prevention and early intervention strategy aimed at supporting families expecting a baby or with children aged up to 8 years. It provides a broad range of universal and targeted support to assist families to raise their children, including the Triple P (Positive Parenting Program) and Safe Start.
- School-Link is a collaborative mental health initiative between NSW Health and the Department of Education and Training (DET). It supports child and adolescent mental health services, schools and TAFE to work together to promote mental health, prevent mental health problems, facilitate identification, treatment, management and support for children and young people with mental health problems in NSW. The School-Link focus has now moved to a greater focus on supporting shared care.
- Resources for schools, including "Supporting students in the HSC years of schooling: Information for Schools".
- A new mental health service delivery model for 14-24 year olds to increase access and delivery in youth friendly settings, co-located with primary health, drug & alcohol and other services (the NSW Youth Mental Health Services Model, including Y-Central on the Central Coast).
- The NSW Early Psychosis Program, to improve outcomes for young people who are experiencing psychosis through evidence based intervention as early as possible.
- Implementation of the NSW Children of Parents with a Mental Illness (COPMI) Framework for Mental Health Services.
- Implementation of *Keep Them Safe Whole Family Teams* in four pilot sites to better address the needs of whole families where carers have mental health and/or drug and alcohol problems and parenting difficulties and there are child protection concerns.
- A new specialist community based forensic Child and Adolescent Mental Health Service established by Justice Health to help young people who were in contact with Juvenile Justice Services.
- Providing support for people at times of vulnerability, such as the Drought Mental Health Assistance Package, and funding for rural mental health project workers.
- Implementation of the *Community Mental Health Strategy, 2007-2012: from prevention and early intervention to recovery*, to achieve recovery oriented community mental health services.
- Implementation of the NSW Health Mental Health, Drug and Alcohol Comorbidity Framework for Action, 2008
- The NSW Aboriginal Mental Health and Wellbeing Policy, 2006-2010, a new detailed framework to address Aboriginal mental health and wellbeing problems in NSW, in a culturally sensitive and appropriate manner.
- The Housing & Accommodation Support Initiative (HASI), to increase support and stable accommodation and improved wellbeing for people with mental illness.
- The Vocational Education, Training & Employment Program (VETE), to enhance self esteem and community partnership for people with serious mental illness. The program offers coordinated pathways and targeted plans to address education and employment needs.
- As part of practices for health and other frontline workers, to help address the risk of, and improve responses to suicide:
  - Additional mental health assessment and treatment capacity in NSW hospitals including the establishment of Mental Health Clinical Nurse Consultant positions in Emergency Departments across NSW.
  - Specialist Psychiatric Emergency Care Centres (PECCs) in the busiest Emergency Departments, and mental health and risk assessment training programs for Emergency Department staff.
  - A Suicide Risk Assessment and Management framework and training program to enhance the capacity of health workers to assess and effectively manage people who may be at risk of suicide. Specific protocols and training have been developed for clinical staff working in mental health and other hospital and community health settings.
  - A standardised discharge policy framework to promote continuity of treatment and ongoing support for people leaving adult mental health inpatient settings and their families and carers.
  - A NSW Health Suicide Prevention for Older People training manual.

- An online training resource, *Cultural Competence in working with suicidality and interpersonal trauma* (CD-ROM).
- Development of more effective partnership arrangements between NSW Health and Community Services in relation to services for children and adolescents in out of home care.
- Community Services' Dual Diagnosis Support Kit, to help workers and families where mental illness and substance abuse coexist.
- Mental Health First Aid training across a number of agencies, including specialised training for Ambulance workers, tailored culturally appropriate and youth focused programs, and specialised suicide and self-harm training for all Youth Officers in Juvenile Justice Centres.
- NSW Police Force Mental Health Intervention Team program, supported by NSW Health, developed to reduce the risk of injury to police and mental health consumers during mental health related events. It aims to improve awareness by frontline police of the risks involved in dealing with mental health consumers and provide strategies to reduce injuries to police and consumers; improve collaboration with other government and non government agencies in the response to, and management of, mental health crisis events; and reduce the time taken by police in the handover of mental health consumers into the health care system.

# Relevant government policies and programs

The NSW Suicide Prevention Strategy is aligned with the national framework for suicide prevention:

- *Living Is For Everyone: a framework for prevention of suicide in Australia*, 2007
- *Living Is For Everyone: research and evidence in suicide prevention*, 2007

It builds on the previous NSW suicide prevention strategy:

- NSW Suicide Prevention Strategy, suicide: we can all make a difference, 1999

The strategy also aligns with a range of national and NSW strategies and policy documents including:

- *Fourth National Mental Health Plan, 2009-2014: an agenda for collaborative government action in mental health*, (2009)
- COAG National Action Plan on Mental Health, 2006-2011, (2006)
- National Preventative Health Taskforce Technical Paper 3: Preventing Alcohol Related Harm in Australia: a window of opportunity, 2008
- Closing the Gap on Indigenous Disadvantage: the challenge for Australia, (2009)
- NSW State Plan: *investing in a better future*, (2009)
- *Keep Them Safe: a shared approach to child wellbeing*, (2009)
- *A Way Home: reducing homelessness in NSW*, 2009
- *Two Ways Together: NSW Aboriginal Affairs Plan, 2003-2012*, (2003)

- NSW Aboriginal Mental Health and Wellbeing Policy, 2006-2010, (2006)
- NSW Interagency Action Plan for Better Mental Health, (2005)
- *NSW Community Mental Health Strategy, 2007-2012: from prevention and early intervention to recovery*, (2007)
- NSW Health Mental Health, Drug and Alcohol Comorbidity Framework for Action, (2008)
- NSS Carers Action Plan 2007-2012
- NSW Multicultural Mental Health Plan, 2008-2012, (2008)
- Framework for Suicide Risk Assessment and Management for NSW Health Staff, (2004)
- *NSW Service Plan for Specialist Mental Health Services for Older People, 2005-2015*
- Mindframe National Media Initiative, [www.mindframe-media.info](http://www.mindframe-media.info)

# Consultation process

A wide range of organisations have actively contributed to the development of the Strategy to date:

## Government agencies

### *NSW Department of Premier & Cabinet*

- Local Government
- Premier & Cabinet

### *NSW Treasury*

### *NSW Health*

- Department of Health
- Greater Southern Area Health Service
- Greater Western Area Health Service
- Hunter New England Area Health Service
- North Coast Area Health Service
- North Sydney Central Coast Area Health Service
- South Eastern Sydney Illawarra Area Health Service
- Sydney South West Area Health Service
- Sydney West Area Health Service
- Children's Hospital at Westmead
- Ambulance Service of NSW
- Justice Health

### *NSW Department of Education & Training*

- Education & Training
- TAFE NSW

### *NSW Police Force*

### *Department of Justice & Attorney General NSW*

- Attorney General's
- Corrective Services NSW

### *Department of Human Services NSW*

- Aboriginal Affairs NSW
- Ageing, Disability & Home Care
- Community Services
- Housing NSW
- NSW Juvenile Justice
- Transport NSW:
  - RailCorp
  - Roads & Traffic Authority

### *NSW Department of Environment, Climate Change & Water*

### *Communities NSW*

- NSW Office of Liquor, Gaming & Racing

### *NSW Commission for Children & Young People*

### *Commonwealth Department of Health & Ageing*

## Non government organisations / other stakeholders

- Aboriginal Health & Medical Research Council
- AIDS Council of NSW
- Alcohol & Other Drugs Council of Australia
- Australian Association of Social Workers
- Australian Centre for Agricultural Health & Safety
- Australian College of Mental Health Nurses
- Australian Infant, Child, Adolescent & Family Mental Health Association
- Australian Primary Health Care Research Institute, Australian National University
- Australian Psychological Society
- Australian Suicide Prevention Advisory Council
- Australian Suicide Prevention Foundation

- Black Dog Institute
- BoysTown
- Brain & Mind Research Institute
- Carers NSW
- Centre for Mental Health Research
- Centre for Rural & Remote Mental Health
- Child & Family Welfare Association of Australia
- Clinical Excellence Commission
- Club Speranza
- Crisis Support Services
- General Practice NSW
- Headspace
- Hornsby Ku-ring-gai Youth Network
- Hunter Institute of Mental Health
- Inspire Foundation
- JARA Concord Centre for Mental Health, University of Sydney
- Lifeline
- Mental Health Association NSW
- Mental Health Coordinating Council
- Mental Health Council of Australia
- Mental Health Review Tribunal
- Multicultural Mental Health Australia
- Neami
- NSW Centre for Advancement of Adolescent Health
- NSW Consumer Advisory Group
- NSW Farmers Association
- NSW Mental Health Consumer Subcommittee
- NSW Mental Health Coordinating Council
- NSW Mental Health Priority Taskforce
- NSW Official Visitors Program
- NSW Transcultural Mental Health Centre
- Peer Support Australia
- Physical Disability Council of NSW
- Public Interest Advocacy Centre
- Private Mental Health Alliance
- Private Mental Health Consumer Network
- Royal Australian & New Zealand College of Psychiatrists (NSW Branch)
- Royal Australian College of General Practitioners
- Salvation Army
- SANE Australia
- Suicide Prevention Australia
- Transcultural Mental Health Centre (Statewide Specialist Service)
- Uniting Care Mental Health
- University of New England
- University of Western Sydney
- Warringah Council
- Woollahra Council
- Wesley Mission (LifeForce)
- White Wreath

# Glossary of terms

Suicidal behaviour includes thinking about suicide, harming oneself or actually taking one's own life. Noting that there are no agreed technical terms for suicidal behaviour – a list of terms and definitions have been used in the Strategy, consistent with the 1999 Strategy and the LIFE framework.

Suicide prevention includes activities aimed at reducing the rate of death and disability resulting from, and the risk factors linked to, suicidal acts.

<i>Suicide prevention:</i>	Activities aimed at reducing the rate of death, disability (mortality and morbidity) resulting from and risk factors linked to suicidal acts.
<i>Suicide:</i>	A suicidal act resulting in death.
<i>Suicidal ideation:</i>	Thoughts about suicidal acts.
<i>Suicidal threats:</i>	Actions suggesting an intention to die from suicide or self-harm.
<i>Suicidal act:</i>	Self inflicted injury with an intention to die from suicide, including self poisoning, possibly resulting in death or serious injury.
<i>Suicidal behaviour:</i>	Suicidal ideation, suicidal threats or suicidal acts.
<i>Attempted suicide:</i>	A suicidal act causing injury but not leading to death.
<i>Self injury:</i>	Deliberate damage of body tissue, often in response to psychosocial distress, without the intent to die. Sometimes called non suicidal self injury, self inflicted injuries, or self-harm.
<i>Deliberate self-harm:</i>	Any behaviours causing destruction or alteration of body tissues, with or without the intent to die, including self injury.
<i>Imminent risk:</i>	The point at which suicide is extremely likely in the near future; intervention may be necessary.
<i>Protective factors:</i>	Capacities, qualities, environmental and personal resources that drive individuals towards growth, stability, and health.
<i>Resilience:</i>	Capacities within a person that promote positive outcomes, such as mental health and wellbeing, and provide protection from factors that might otherwise place that person at risk of suicide. Resilience is often described as the ability to bounce back from adversity. Factors that contribute to resilience include personal coping skills and strategies for dealing with adversity, such as problem solving, cognitive and emotional skills, communication skills and help seeking behaviours.
<i>Risk factors:</i>	Factors such as biological, psychological, social and cultural agents that are associated with suicide/ suicide ideation and increase their probability. Risk factors can be defined as either distal factors, such as genetic or neurochemical factors, or proximal factors, such as life events or the availability of lethal means – factors which can 'trigger' a suicide or suicidal behaviour.
<i>Tipping point:</i>	The point at which a person's risk of suicide increases due to the occurrence of some precipitating event, such as a negative life event or an increase in symptoms of a mental disorder.
<i>Warning signs:</i>	Behaviours that indicate a possible increased risk of suicide, such as giving away possessions, talking about suicide or the withdrawal from family, friends and normal activities.
<i>Whole of community:</i>	Individuals, families, neighbourhoods, schools, community groups, government and nongovernment services, and communities working together across NSW.
<i>Whole of government:</i>	Collaboration and cooperation between all NSW Government agencies.

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