

# Proposed Suicide Prevention Framework for NSW



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## TABLE OF CONTENTS

<b>Executive summary .....</b>	<b>3</b>
<b>Introduction .....</b>	<b>5</b>
Background and rationale.....	5
<b>Systems Approach to Suicide Prevention .....</b>	<b>8</b>
Component 1: Implement evidence-based suicide prevention strategies in local areas, simultaneously ....	10
Component 2: Adopt a common evaluation framework across local areas .....	13
Component 3: Engaging local communities, such as health services, schools, community agencies, worksites, rural and remote services, and the police, in suicide prevention .....	18
Component 4: Establish good implementation, governance, resources and processes at central and local areas .....	23
<b>Acknowledgements .....</b>	<b>27</b>

## EXECUTIVE SUMMARY

In 2013, 2,522 Australians died by suicide, with a national suicide rate of 10.9 per 100,000 population. In NSW, almost 700 people died by suicide in the same period, and it can be estimated that over 20,000 made an attempt. Yet, we know that suicide is preventable. People approaching acts of suicide are ambivalent, have been in recent contact with health services, and suicidal urges fluctuate and can drop over hours. Moreover, evidence suggests that many medical and community interventions can prevent suicide, suicide attempts and suicidal thoughts. Evidence is mounting that the best results may be gained from a multilevel, multifactorial, systems-based approach.

This Framework document aims to describe how organisations, the community and the government can develop and implement the best possible approach to lowering suicide rates in NSW.

The Suicide Prevention Framework for NSW is based on the internationally recognised “systems approach” to suicide prevention. Although there are many conceptualisations of a systems approach, the core is that multiple interventions are implemented in a cohesive manner across a spectrum ranging from population-based public health measures through to medical interventions targeting the individual. Examples of systems approaches include the World Health Organization’s (WHO) “Preventing Suicide” report<sup>1</sup> and “zero suicide”, a key concept of the 2012 National Strategy for Suicide Prevention in the USA<sup>2</sup>.

The core principles of the systems approach in the present Framework are that suicide prevention requires involvement of all medical, government, health and community agencies within in a **local/regional area** at the same time, demonstrating sustainability and long-term commitment. This involvement requires the implementation of evidence-based suicide prevention strategies and the integration of a response across agencies.

The development of the Framework arose from the publication of *Living Well*, the NSW Mental Health Commission’s Strategic Plan for Mental Health in NSW 2014-2024<sup>3</sup> combined with the release of the National Mental Health Commission’s *Review of Mental Health Services and Programmes*<sup>4</sup>. During March 2015, the NSW Mental Health Commission engaged the NHMRC Centre of Research Excellence in Suicide Prevention (CRESP) to develop a statewide Suicide Prevention Framework, to guide suicide prevention activities in NSW over the next 3-5 years. CRESP established a Suicide Prevention Steering Group to inform development of the Framework, drafted a preliminary document and sent it out for consultation to a broad group of public, industry and community sector leaders, including those with lived experience of suicide. The consultation process involved face-to-face workshops, telephone interviews and an online survey. This final Framework document is based on the results of that consultation.

The Framework has four components. The first component describes the implementation of nine evidence-based best practice strategies operating simultaneously across medical, government, health and community agencies. These strategies span the continuum of universal, selective and indicated suicide prevention interventions. Each strategy, whether population-based or individually directed, adds cumulatively to reduce suicide deaths and attempts.

The second component requires the adoption of a common evaluation framework. An evaluation framework makes sense both scientifically and practically: scientifically, because it allows policy makers and the public to know whether progress is being made; practically because it necessitates the design and collection of the best possible data on suicide in an environment where such data capture has not previously existed.

The third component requires a sophisticated community and health system engagement and implementation strategy, because the Framework is complex and requires ownership and co-operation across multiple agencies. Indeed, organisations consulted suggested that this was critical in developing a workable Framework.

The fourth component is a flexible but responsible governance arrangement.

## Models and risk factors

Social factors play an important role among the multiple determinants of suicide. Risk factors of poverty, unemployment, disability, traumatic life circumstances and intergenerational conflicts are associated with suicide risk. Further, it follows that promoting a just, socially responsive, culturally respectful, non-discriminatory, connected society and an environment where young people can grow up non-traumatised, can reduce suicides in Australia. However, the focus of the present Framework is not about these broad and important risk factors; rather, it is about initiating proven actions that can be taken now by health, community and government organisations to reduce suicide attempts and deaths. A focus on the social determinants of suicide risk, mental health and stigma must continue, but the Framework is driven by a focus on instigating proven actions.

## Specific community groups

For Aboriginal people, specific risk factors and cultural adaptations need be taken into account when implementing the Framework. The present approach to Aboriginal and other cultural perspectives, is addressed via our focus on local implementation plans. Similarly, responses tailored to higher suicide risk groups such as youth or older people need to be considered within the local plan.

## The Suicide Prevention Framework model

The Framework describes broad population-level interventions through to individually tailored responses through treatment and assertive outreach. The evidence supporting each of the actions is synthesised from a variety of sources, such as literature reviews<sup>5</sup>, literature review for the development of the Report Card undertaken by the CRESP for the National Mental Health Commission in 2013, the CRESP database of randomised controlled trials related to suicide prevention and new work in the area of the systems approach.

The primary objectives of this Framework are to:

- Increase awareness about the magnitude of the problem of suicide in NSW and the availability of prevention strategies;
- Describe how organisations, the community and the government can develop and implement the best possible approach to lowering suicide rates in NSW.

The WHO's global aim is to reduce suicide rates in countries by 10% by 2020. Suicide Prevention Australia (SPA), a national organisation providing leadership for the suicide prevention sector, aims for a 50% reduction in suicides in Australia by 2023. Given existing evidence, it can be expected that this Framework, if implemented, could lead to a substantial drop in suicide rates in NSW.

# INTRODUCTION

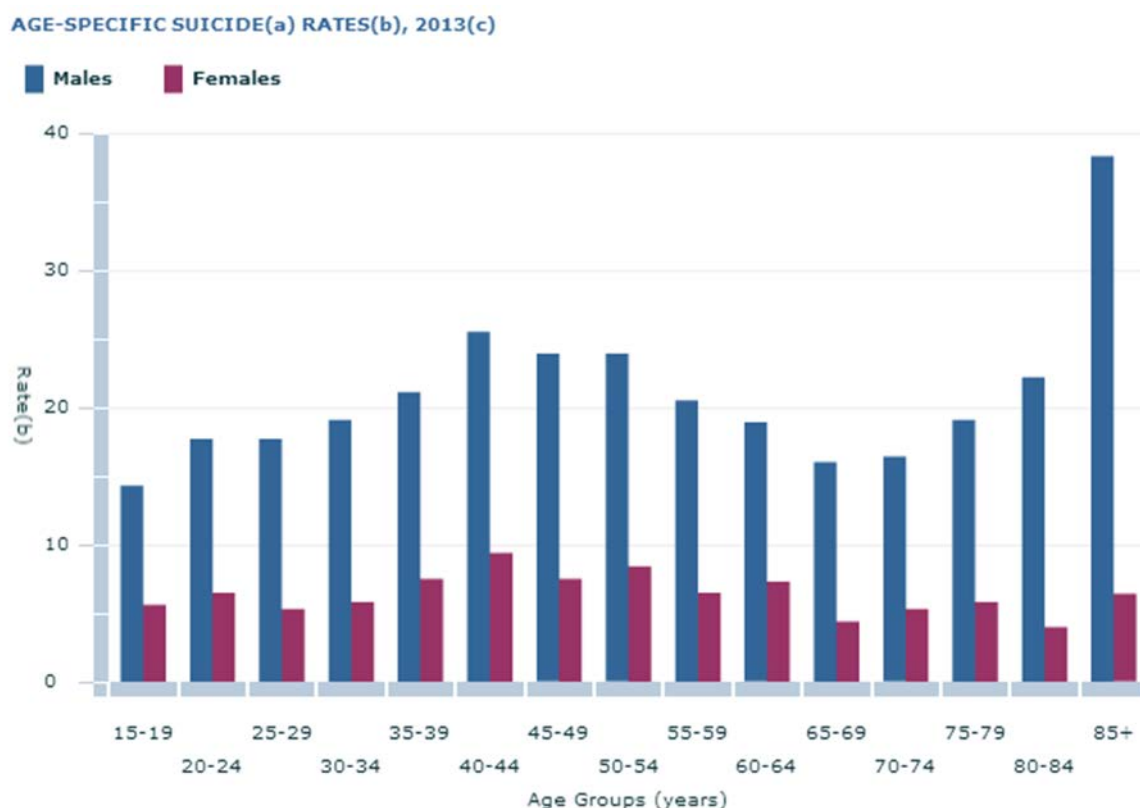
*Health and community providers implement evidence-based, best practice strategies at the local area at the same time: A systems approach.*

## Background and rationale

### Suicide in Australia and NSW

In 2013, 2,522 Australians died by suicide, with a national suicide rate of 10.9 per 100,000 population<sup>6</sup>. About three quarters of those who died by suicide were men, and the male suicide rate in 2013 was three times higher than the female rate (16.3 per 100,000 and 5.4 per 100,000, respectively). The highest age-specific suicide death rate for men in 2013 was observed in the 85 years and over age group, with the second highest rate in the 40-44 year age group (38.3 per 100,000 and 25.5 per 100,000 respectively) (Figure 1). Though those aged 85 years and over had the highest age-specific rate, suicide deaths only represented 0.3% of total deaths in this group. In contrast, 34.8% of all deaths among the 15–19 year group were suicide deaths, but that age group had the lowest age-specific suicide rate (14.3 per 100,000)<sup>7</sup>. Among women, the highest age-specific suicide death rate in 2013 was observed in the 40-44 year age group (9.4 deaths per 100,000), which represents a major change in suicide trends from 2012, where the 80-84 year group had the highest age-specific rate. The most frequently used suicide method was hanging (more than half of suicide deaths), followed by self-poisoning, firearm, drowning, jumping from a high place, and other methods. The suicide rate in Aboriginal people (male and female) in 2013 was twice as high as the suicide rate in non-Indigenous Australians<sup>8</sup>.

**Figure 1. Age-specific suicide rates, 2013.**



Source: ABS (2015)

In 2013, 694 people died by suicide in NSW, with a state suicide rate of 9.2 per 100,000 (13.6 per 100,000 for men and 4.9 per 100,000 for women)<sup>9</sup>. It is further estimated that there are about 30 suicide attempts for every completed suicide, equating to around 21,000 attempts per annum in NSW. The suicide rate in Aboriginal people in NSW exceeded the non-Aboriginal suicide rate (12.1 per 100,000 and 9.0 per 100,000, respectively) and suicide was the ninth leading cause of death in that population<sup>10</sup>.

Suicide is one of the three leading causes of death in the economically most productive age group, that is, those aged 15 to 44 years<sup>11</sup>, and suicide rates have risen globally since the global financial crisis in 2008<sup>12</sup>. While there are no definitive estimates of the financial cost of suicide nationally, a 2009 report using figures from the Australian Bureau of Statistics and the Australian Institute of Health and Welfare estimates the economic burden of suicide on the Australian community to be \$17.5B annually<sup>13</sup>. As such, the human and economic costs of suicide are substantial.

## Risk and protective factors

Suicidal behaviour results from complex interactions between a wide range of risk and protective factors encompassing the entire life span of an individual<sup>14</sup>. It is a complex behaviour, underpinned by a multitude of risks spanning individual, familial, community and societal domains (Table 1). Mental health problems most frequently related to suicidal behaviours include: mood disorders, such as major depression and bipolar disorder; schizophrenia and other psychotic disorders; substance-related disorders; personality disorders (especially borderline and antisocial personality disorder); anxiety/somatoform disorders, including posttraumatic stress disorder; and adjustment disorder. A history of a suicide attempt is the major risk factor for suicide. Individuals who attempt or complete suicide often experience stressors and negative life events, especially in the months preceding the suicidal behaviour. These stressors can include interpersonal conflicts, relationship breakdown, bereavement, physical illness, unemployment, job problems, financial problems, domestic violence, and serious injury or assault<sup>15</sup>.

Psychological characteristics or vulnerabilities, such as aggression and impulsivity, lack of reasons for living, poor problem solving skills, perfectionism, worry and rumination might exacerbate the impact of other risk factors<sup>16</sup>. Hopelessness, a state of negative expectancies concerning oneself and one's future, is one of the strongest predictors for suicidal ideation and behaviour, stronger even than depression itself. Also, psychological suffering and psychological pain is strongly linked to a higher suicide risk.

There is an association between marital status and suicide: divorced, widowed, and separated people have the highest suicide rates, and married people have lower suicide rates than those who have never married. Although the lesbian, gay, bisexual, transgender and intersex (LGBTI) community rates do not appear to be higher than the rest of the population, there is a greater lifetime prevalence of suicide attempts in the LGBTI community, especially among young people.

Loneliness may lead to depression and emotional distress or increase their severity, as well as exacerbate the effects of negative stressors. According to the interpersonal theory of suicide<sup>17</sup>, a feeling of being a burden to others and a feeling of loneliness accompanied by an acquired capacity for suicide, such as lowered fear of death and increased tolerance for physical pain, are common experiences of individuals at risk of suicide.

**Table 1. Risk factors for suicide (non-exhaustive)**

Individual	Socio-cultural/situational
<ul style="list-style-type: none"> <li>• Family history of suicidal behaviour</li> <li>• Mental illness: mood disorders, schizophrenia and other psychotic disorders, and substance-related disorders</li> <li>• Previous history of suicidal behaviour</li> <li>• Childhood and adult trauma</li> <li>• Low coping potential</li> <li>• Hopelessness</li> <li>• Aggression and impulsivity</li> <li>• Worry and rumination</li> <li>• Psychological pain</li> <li>• Neurobiological and genetic factors</li> <li>• Drug and/or alcohol use</li> </ul>	<ul style="list-style-type: none"> <li>• Indigenous status</li> <li>• Exposure to suicidal behaviours through sensationalist reporting by the media</li> <li>• Access to and availability of lethal means of suicide</li> <li>• Unemployment or financial crisis</li> <li>• Stressful life events</li> <li>• Relationship breakdown</li> <li>• Poor social networks</li> <li>• Social isolation, lack of social support</li> <li>• Imprisonment</li> <li>• Bereavement</li> </ul>

Sufficiently strong individual, community and socio-cultural protective factors can reduce the risk of suicide. These include employment, family and nonfamily social support, significant and stable relationships (including marriage), and children under the age of 18 living at home. Marriage and responsibilities for bringing up children may serve as a protective factor against suicide by reducing social isolation, providing emotional and social stability, and enhancing social integration. Good physical health, effective problem-solving and coping skills, hopefulness, strong reasons for living, having plans for the future and constructive use of leisure time are also protective factors. The availability of effective treatment, an individual's readiness to utilise and maintain it when needed, as well as restricted access to lethal means of suicide can also play a significant protective role.

### Suicide is preventable

Despite this constellation of risk factors, suicide is recognised as preventable, as people contemplating suicide are ambivalent, have been in recent contact with health services, and suicidal urges fluctuate and can drop over hours<sup>18</sup>. Moreover, evidence suggests that many medical and community interventions prevent suicide, suicide attempts and suicidal thoughts. Empirical research supports that suicide prevention is cost effective, and that there is return on investment for at least a number of suicide prevention interventions, such as sustained training of general practitioners (GPs) which leads to adequate treatment (e.g. cognitive behavioural therapy followed by ongoing pharmaceutical and psychological support)<sup>19</sup>. Yet, despite this knowledge, suicide rates have not lowered significantly in Australia or NSW in the last decade. Progress is hampered by the lack of integration and poor coordination of suicide prevention activities and strategies. This is an ineffective approach to prevention. A fresh approach, based on new research and practice, is required.

### Context for the current framework

Australia was one of the first countries to develop a national suicide prevention strategy in 1995. It focussed on young people at higher risk of suicide. From 1999, the National Suicide Prevention Strategy expanded its target to suicide prevention across the life span. Since that time the National Suicide Prevention Strategy has been reviewed and redeveloped to reflect new evidence.

NSW established its first whole of government, whole of community suicide prevention strategy in 1999 with *Suicide: we can all make a difference*<sup>20</sup>. The NSW Ministry of Health developed the *NSW Suicide Prevention Strategy 2010-2015*<sup>21 22</sup>, which set out the NSW Government's strategic directions and intended outcomes for

suicide prevention in NSW over the period 2010-2015, and aligned with the national suicide prevention framework *Living Is for Everyone*<sup>23</sup>. The Strategy was developed to provide the basis for a coordinated whole of government approach to suicide prevention in NSW, and it 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.

More recently, a Ministerial Advisory Committee (MAC) on Suicide Prevention was convened in 2012 with a view to further engaging those with lived experience and the community in decreasing the suicide rate in NSW through grassroots community action. The then NSW Minister of Mental Health asked the Mental Health Commission of NSW to develop a draft implementation plan in order to progress the recommendations of the MAC. The Commission undertook initial consultations during July and August 2013 with the MAC and other stakeholders, regarding the strategies, and the identification of lead agencies and partners, for the implementation plan. In December 2014, government agencies determined that a high level Framework would be preferable to an implementation plan. As a result, during March 2015 the NSW Mental Health Commission engaged the NHMRC Centre of Research Excellence in Suicide Prevention (CRESP) to develop a state-wide Suicide Prevention Framework, to guide suicide prevention activities in NSW over the next 3-5 years.

The primary objectives of this Framework are to:

- Increase awareness about the magnitude of the problem of suicide in NSW and the availability of prevention strategies;
- Describe how organisations, the community and the government can develop and implement the best possible approach to lowering suicide rates in NSW.

## SYSTEMS APPROACH TO SUICIDE PREVENTION

A systems approach to suicide prevention recognises that successful suicide prevention requires a multilevel, multifactorial approach, involving both healthcare and community professionals and organisations, along with government and non-government agencies, reflecting the fact that suicide is the result of an accumulation of risk factors, and has multiple points for intervention. The success of the systems approach requires buy-in from the community – including leaders of banks, large companies and businesses. It also must involve those with lived experience, i.e. people who have survived and attempt and/or been directly or indirectly affected by the suicide or attempted suicide of someone they know. Each system involved must move in concert with other systems to put all evidenced-based interventions into action simultaneously. This approach reflects a revolution in policy and practice.

### Defining a systems approach: core features

The core features of the Suicide Prevention Framework for NSW are:

- 1. Multisectorial involvement by all government, non-government, health, business, education, research and community agencies and organisations**
- 2. Within a localised area**
- 3. Implementing evidence-based strategies at the same time**
- 4. Demonstrating sustainability and long-term commitment.**

The systems approach is similar to, but different from, other suicide prevention frameworks that call for integrated strategies. It puts emphasis on all relevant organisations and services to work together in an integrated fashion, simultaneously and at a localised level. A localised approach encourages community ownership of suicide prevention activities and encourages community members to have an active role in the planning, development, implementation and maintenance of suicide prevention activities. Unlike other suicide



prevention frameworks, the present Framework recommends implementation of suicide prevention strategies that have proven effectiveness. It serves to shift activities away from those that have no proven effectiveness. Moreover, this strategy represents an all-ages response to suicidal behaviour. An all-ages response, however, does not preclude services and agencies from using a targeted approach to address specific needs or high-risk groups.

Three main elements are essential to the successful local implementation of a systems approach<sup>24</sup>:

1. Carrying out a **“suicide audit”**: this involves the collection of data about suicides that have occurred locally from sources such as coroners and health records in order to build an understanding of local factors such as high risk demographic groups. Good quality outcome statistics are critical to informing suicide prevention priorities and to the evaluation of the impact of prevention strategies.
2. The development of a **suicide prevention action plan** setting out the specific actions that will be taken to reduce suicide risk in the local community. This plan will consist of a set of core principles that each community needs to adhere to, based on best evidence, but the strategies can be tailored to address unique community needs.
3. The establishment of a **multi-agency suicide prevention group** involving all key statutory agencies, medical, health and community organisations whose support is required to effectively implement the plan throughout the local community and provide leadership.

### Evidence for the effectiveness of a systems approach

A systems approach to suicide prevention has not been done before in Australia, but there is global evidence that this approach is clinically effective. One of the earliest examples of this approach is the Nuremburg Alliance Against Depression (NAAD), which was a two-year community-based intervention program, comprised of four strategic levels: co-operation with primary care; public relations campaign; community facilitators and high-risk groups; and self-help. Each level contained multiple strategies. An evaluation found statistically significant reductions in suicidal acts (deaths and attempts) during the two years in the intervention region of Nuremburg, as compared to the control region (2000 vs. 2001: 19.4% reduction in suicidal acts; 2000 v. 2002: 24% reduction). One year after the intervention finished, there remained a 32% reduction in suicidal acts as compared to the 2000 rate<sup>25</sup>.

The success of the NAAD led to the development of a broader European systems approach to suicide prevention, using the same principles as the NAAD. It was similarly successful. For example, in Hungary, the annual suicide rate in the intervention region decreased from 30.1 per 100,000 in 2004 to 13.2 per 100,000 in 2005, 14.6 in 2006, and remained as low as 12.0 in 2007, one year after the end of the intervention. In comparison, annual suicide rates slightly increased during this period in the control region<sup>26</sup>. The effects of the systems approach intervention in the intervention region were quite large, with the region experiencing a 56% decrease in suicide rates, compared to a 10% decrease in the overall national trend, and a 2% increase in the control region. These European interventions demonstrate that a systems approach can effectively reduce suicide.

### The Suicide Prevention Framework for NSW consists of four major components:

1. **Implement evidence-based suicide prevention strategies in local areas, using existing community structures and initiatives where possible.**
2. **Adopt a common evaluation framework across local areas.**
3. **Engage local communities, such as health services, schools, community agencies, worksites, rural and remote services, and the police, in suicide prevention, and build capacity and readiness across these organisations within the community.**
4. **Establish good implementation, governance, resources and processes at central and local areas.**

Each component is discussed in detail in the following.

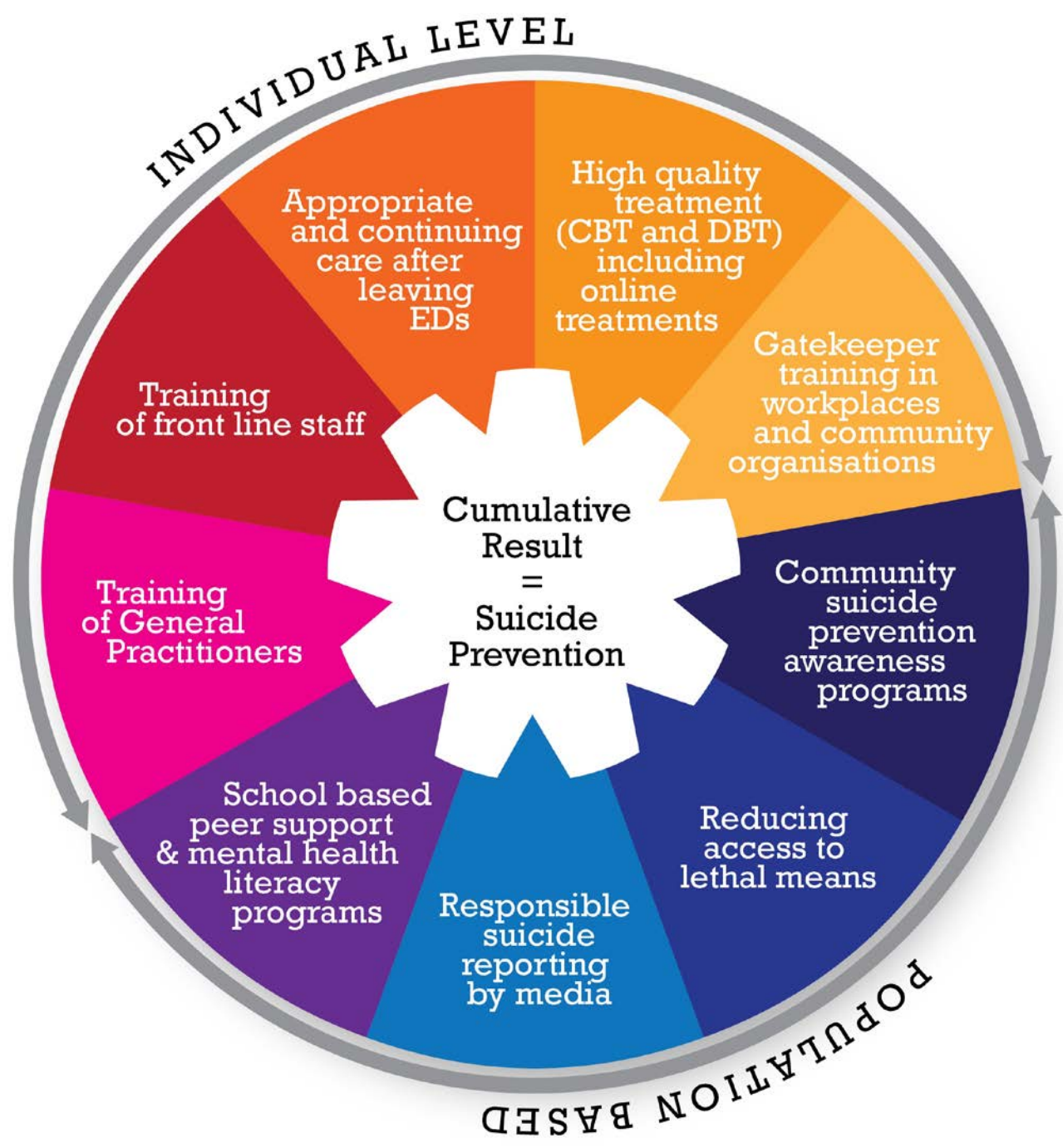
## Component 1: Implement evidence-based suicide prevention strategies in local areas, simultaneously

At the core of the systems approach is the implementation of a set of evidence-based best practice strategies locally, and at the same time across multiple sectors, demonstrating sustainability and long-term commitment. This set of core strategies will be implemented in all communities that choose to take up the systems approach. It will be a responsibility of each community to define what strategies will be used, allowing them flexibility to design activities that address the needs of their community. These strategies should span the continuum of universal, selective and indicated suicide prevention interventions.

There are nine suicide prevention strategies ranging from individual to community approaches (Figure 2):

1. Appropriate and continuing care once people leave Emergency Departments (ED), and for those at risk in the community at any one time:
  - a. 24/7 call out emergency teams experienced in adult/child/adolescent suicide prevention;
  - b. Crisis-call lines and chat services for emergency callers;
  - c. Assertive outreach for those in the ED and discharged including those hard to engage with;
  - d. E-health services of web programs through the Internet.
2. High quality treatment, such as Cognitive Behavioural Therapy (CBT) and Dialectical Behaviour Therapy (DBT) for those with mental health problems (including online treatments).
3. Training of GPs in detecting depression and dealing with suicide risk.
4. Suicide prevention training of front line staff every three years, including police, ambulance other first responders.
5. Gatekeeper training for persons who are likely to come into contact with at risk individuals (teachers, youth workers, friends and family, clergy, counsellors). Provision of training in appropriate work places, in particular communities (Aboriginal communities) and across other services targeting particular populations, such as people who interact with those with a disability, or unemployed, or in financial crisis, people dealing with child trauma, rape, violence, etc.
6. School-based peer support and mental health literacy programs.
7. Community suicide prevention awareness programs about suicide.
8. Responsible suicide reporting by the media.
9. Reducing access to lethal means of suicide.

Figure 2. Nine prevention strategies, from population level to individual level, add cumulatively to reduce suicide.



Each strategy, whether population-based or individually directed, adds cumulatively to reduce suicide deaths and attempts.

The systems approach recognises that not all strategies will be equally effective; some operate further upstream than others. Prioritisation of strategies will depend on many local-level factors, such as existing services and suicide prevention initiatives already implemented as well as gaps identified through an audit of services and programs. Not all local areas will have all nine strategies in place or available. Indeed, depending on the size of the area, some local areas may only have one or two of the strategies covered. It is impossible to say how many of these interventions are required to maximise the preventative effect, although the most promising interventions are means restriction, GP education, and gatekeeper training<sup>27</sup>. Moreover, given the evidence is weakest for community awareness programs, such programs need to be run parallel to other interventions, rather than representing an effective stand-alone prevention activity. In short, the goal is that strategies are introduced and implemented in each local area with local resources simultaneously, demonstrating sustainability and long-term commitment. Gaps in service provision will serve as basis for advocating for/or creating health and other systems changes that will bring the community into alignment with best practice. There may be opportunities for organisations to change or redirect their services.

Each local area will have its own unique population of recipients. Groups with increased suicide risk are presented in Table 2.

Table 2: Groups with increased risk of suicide	
1.	People living in socioeconomically deprived conditions, including unemployed and homeless people
2.	People living in rural and remote areas
3.	Aboriginal and Torres Strait Islander people or communities
4.	People in the justice system, and immediately after release from prison
5.	People with lived experience of mental illness
6.	People with a history of previous suicide attempt/s
7.	People who use alcohol and/or drugs
8.	People dealing with trauma in the workplace, including first responders (e.g. police, paramedics) and former defence force personnel
9.	People bereaved by suicide
10.	People from culturally and linguistically diverse backgrounds
11.	People from the LGBTI community
12.	Men

These high-risk groups need to be considered when designing the content and method of delivering the systems approach strategy. Within a local area, high risk groups may influence the range and type of services available to align to the core strategies, as well as the specific needs of the populations of each of the communities. For example, if an area has a greater proportion of refugees, then efforts should be directed to frontline training of community organisations that support this population. In another local area, the prison population may require special prevention efforts, and training in suicide prevention should extend to those working in prisons.

The Framework, in order to be effective, currently focuses on the nine strategies presented above. The Framework is deliberately restrictive in focusing on evidence-based strategies for two reasons: (1) to prioritise those actions most likely to result in quick wins based on the available evidence; and to (2) to exclude strategies that are not sufficiently evidence-based. Simply endorsing all current suicide activities not supported by current evidence is pointless. Suicide rates have not changed in the last 10 years and continuing to endorse more of the same will not substantially effect changes in suicide rates. For example, almost any activity that addresses mental health can be interpreted as a suicide prevention activity, yet such initiatives have rarely been shown to lower suicide risk specifically. Consequently, although these activities are important, they are not incorporated into the current Framework.

## Component 2: Adopt a common evaluation framework across local areas

*For the first time, using a common evaluation method, we will be able to detect whether the Framework has saved lives.*

A high level evaluation strategy is an important component of the Suicide Prevention Framework for NSW. Ultimately the success of a suicide prevention program is measured by a reduction of deaths and a reduction of non-fatal suicide outcomes. In order to do this, the Framework requires the adoption of a common evaluation framework. If adopted successfully, we will, for the first time in Australia, be able to detect whether a planned approach has reduced deaths and attempts.

Overall, the primary testable hypothesis of a systems approach to suicide prevention, where all evidence-based strategies are implemented simultaneously, is that it will create significant reductions in suicide attempts and deaths. Assessments should be made pre-and post-implementation in local areas. Moreover, some intervention regions will roll out their local strategies before others, in a staggered design, so it will be possible to determine local changes in suicide rates relative to ‘control areas’, i.e. those communities which have not yet rolled out their strategies. This provides a strong evaluation strategy.

The key components of a Suicide Prevention Framework for NSW evaluation strategy should be:

1. The development of a central data collection hub for outcome measures and health service availability
2. Local common data collection measures
3. Process and engagement data collection.

### Develop a central data collection: suicide deaths and attempts and service provision

The evaluation requires sophisticated central data collection. Data on outcome measures (suicide deaths, attempts) and healthcare services will need to be acquired, mapped, and spatially analysed to identify the level of suicide risk across NSW as a function of local area. Data needs to be collected over a substantial period (up to 10 years prior to intervention) in order to compare general fluctuations in deaths across time with the impact of a systems approach. It is equally important to continue to collect data for an extended period post-implementation to observe and evaluate the effectiveness of the strategy across time. Examples of primary outcome data sources are described in Table 3.

Table 3. Central data collection
<p><b>Australian Bureau of Statistics (ABS) mortality data (suicide deaths)</b></p> <p>Data is provided to the ABS by the National Coronial Information System (NCIS) and the Registry of Births, Deaths and Marriages. Statistics on all suicide deaths registered in Australia, where the underlying cause of death was determined as intentional self-harm (suicide) (ICD 10-AM codes: X60-X84, Y87.0). Data to be provided at Statistical Area Level 2 (SA2) geography. Age and sex breakdowns are not available to due confidentiality issues in regions where suicide numbers are low (less than 5 deaths over the observed time period).</p> <p><b>Turning Point Ambulance Data (suicide attempts)</b></p> <p>Activities performed by the ambulance paramedic are recorded electronically through an e-Patient Care Record (PCR). These electronic records are downloaded onto the Victorian Ambulance Clinical Information System (VACIS), which contains data from all states on the details of incident. Turning Point has created their own internally-validated database from VACIS data, where they have manually coded various project-</p>

specific data for events as suicide attempts. Multiple electronic PCRs for the same patient are aggregated and a random selection of cases is reviewed to ensure the manual coding was accurate and consistent. Data is able to be provided at unit level, which is the location of where the incident took place.

#### **Admitted Patient Data Collection (suicide attempts)**

The NSW Admitted Patient Data Collection (APDC) records all inpatient separations (discharges, transfers and deaths) from all public, private, psychiatric and repatriation hospitals in NSW, as well as public multi-purpose services, private day procedure centres and public nursing homes. Data are provided where the primary diagnosis of hospital separations are coded as intentional self-harm (suicide) (ICD 10-AM codes: X60-X84). Data is provided at a SA2 geographical level, and age and sex variables are provided.

#### **Healthdirect Australia: health service data**

Healthdirect Australia is able to provide geographical data on density of a wide-range of health services through their National Health Services Directory, including GPs and their networks, psychologist and psychiatrist networks, hospitals, and other broader, community mental health services.

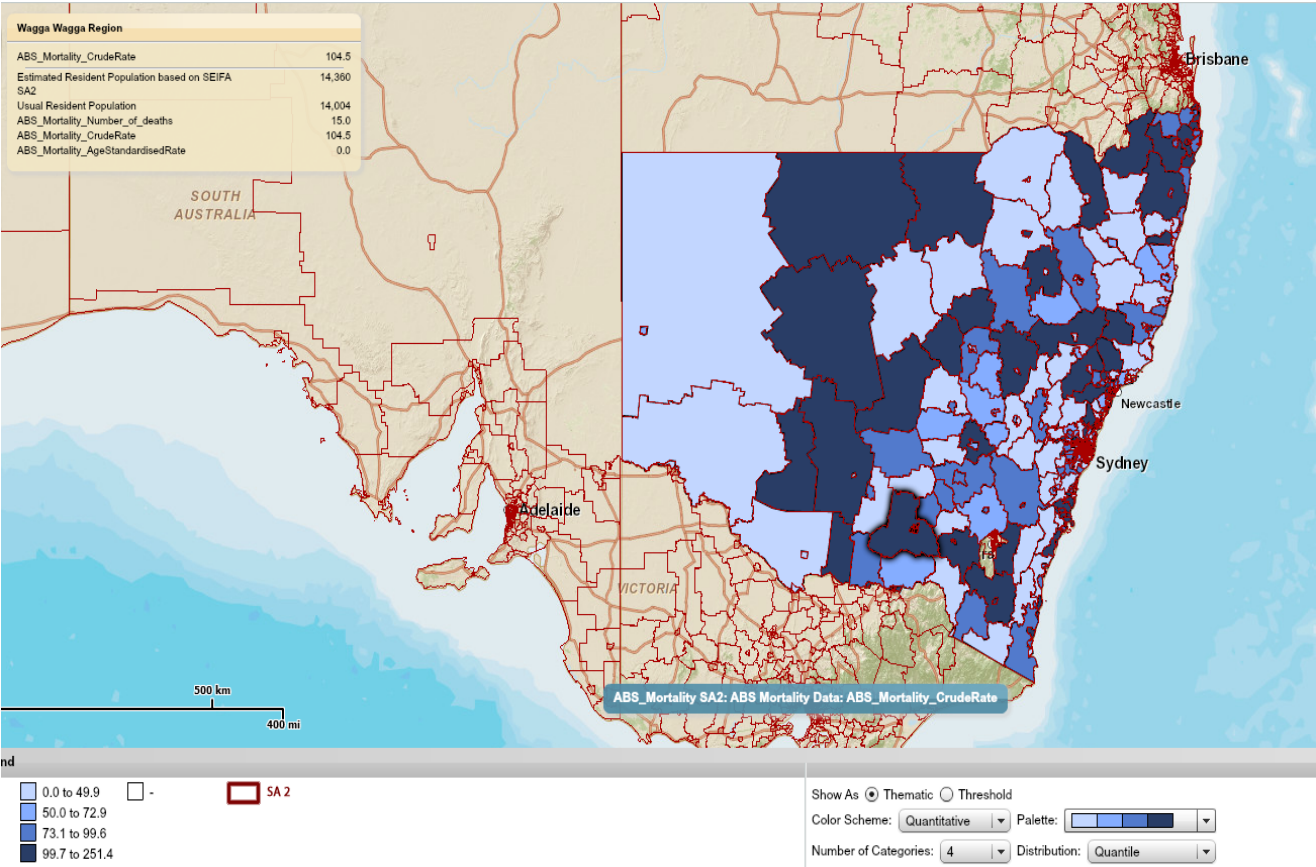
#### **Additional suicide outcome data sources might include:**

1. National Coronial Information System;
2. National surveys (e.g. National Survey of Mental Health and Wellbeing; Ten to Men);
3. Emergency Department data collection;
4. Medicare Benefits Schedule (MBS) and Pharmaceutical Benefits Scheme (PBS) data sets.

An example of the type of mapping to be used for evaluation is illustrated in Figures 3 and 4.

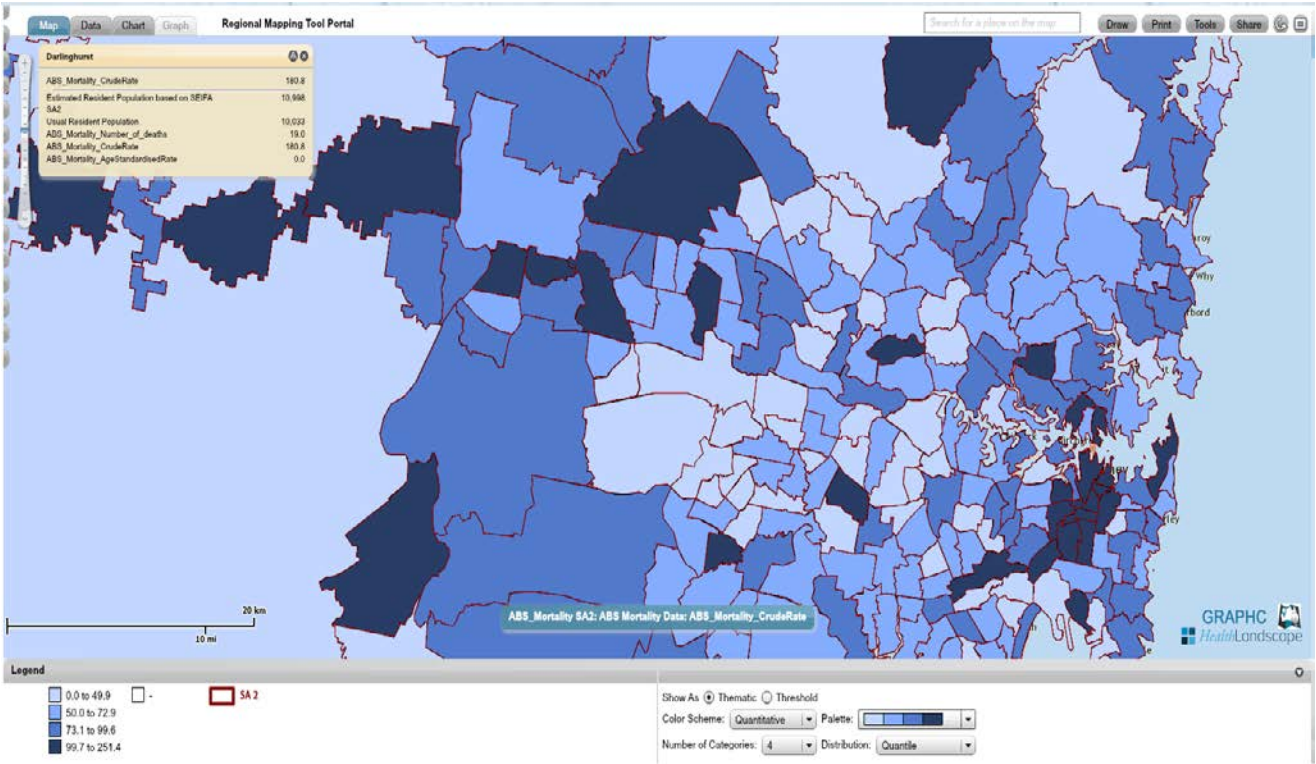


Figure 3. Mapping the number of suicide deaths in NSW 2005 – 2013



Data provided by ABS, Causes of Death, 2013

Figure 4. Close-up view of suicide deaths in NSW 2005 - 2013



Ideally, all data sources used to assess suicide and service provision in NSW will have comparable sources in other states, to facilitate national evaluation of the effectiveness of the strategy. Also, accessing linked data would provide a valuable source of information on at risk individuals' use of health services.

There should be two primary functions of a central data collection:

1. To facilitate information sharing across services, agencies and businesses engaged in prevention activities;
2. To develop a suicide register, i.e., a purpose-designed suicide surveillance system, which brings together coronial, police, health and other proximal data (e.g. unemployment) on deaths by suicide and suicide attempts.

### Local common data collection: suicidal behaviour, depression, suicide literacy and stigma

Each of the nine strategies can be evaluated using common data tools administered within each of the local areas. Overall, few common instruments are required to measure pre/post change, and the scales to evaluate change should be short and universal (Table 4). Each organisation can be evaluated on the extent of pre/post change within its organisational structure.

<b>Prevention strategy type</b>	<b>Indicators</b>	<b>Recommended measurement tools</b>
Appropriate and continuing care once people leave emergency departments	Reduce risk of future suicide attempts and suicide; increase support networks	Suicidal Ideation Attributes Scale (SIDAS) <sup>28</sup> Suicidal Behaviours Questionnaire-Revised (SBQ-R) <sup>29</sup> Patient Health Questionnaire (PHQ-9) <sup>30</sup> (Depression)
High quality treatment (CBT and DBT) for those with mental health problems	Decreasing risk factors and enhancing protective factors; improved coping skills	Suicidal Ideation Attributes Scale (SIDAS) Suicidal Behaviours Questionnaire-Revised (SBQ-R) Patient Health Questionnaire (PHQ-9) (Depression)
Training of general practitioners in detecting and dealing with suicide risk	Increase in GPs knowledge of suicide risk; increasing help-seeking through referral	Stigma of Suicide Scale (SOSS) <sup>31</sup>
Suicide prevention training of 'front line' staff every three years	Increased suicide prevention skills and confidence; recognising suicide warning signs	Literacy of Suicide Scale (LOSS) <sup>32</sup> Stigma of Suicide Scale (SOSS) % of services trained
Gatekeeper training in appropriate settings (e.g. workplaces, schools)	Increased suicide prevention skills and confidence; improved help-seeking behaviour	Literacy of Suicide Scale (LOSS) Stigma of Suicide Scale (SOSS) % of services trained



School based suicide prevention programs	Increased mental health literacy (knowledge and attitudes); increased skills and confidence in referring peers/students	Suicidal Ideation Attributes Scale (SIDAS) Stigma of Suicide Scale (SOSS) Literacy of Suicide Scale (LOSS)
Community suicide prevention awareness programs	Improved awareness and understanding of suicide risk and protective factors, prevalence and available services; reducing suicide stigma; increase in help seeking behaviour	Stigma of Suicide Scale (SOSS) Literacy of Suicide Scale (LOSS)
Responsible suicide reporting by the media	Responsible reporting by media, including not reporting specific details, providing contact details to crisis services, and not glorifying suicide; decreased "suicide contagion" effect	AUDIT: collect media reports of suicide before implementation and post-implementation and analyse content; surveys of media agencies to assess extent of compliance with guidelines
Reducing access to lethal means of suicide	Decreased number of suicides in identified "suicide hot spots"	AUDIT: police reports of suicides at "suicide hot spots"

Measurement tools and scales used in Aboriginal health and other services, and those acceptable to other minority groups should be considered and pretested before use in the intervention, and may require the establishment of consultative groups. If used, they should be calibrated to the standard tools above if at all possible. The same principle applies to standard scales currently used in services serving particular populations, such as corrective services or schools.

Recognising that local data collection may be challenging, the Framework is committed to centralised data collection for major outcome variables. For local data collection, innovative technologies might be employed to get data collected from local services in an automated, timely manner, and linked to standard reporting structures. These measures can be readily distributed in the form of apps which allow agency data to be collated centrally, are easy to use and can be collected. It may be useful to employ data brokers to set up systems within local areas, to offer training and support for data collection and display. Local sites might consider developing a tool box of measures that might suit different local areas, but given the challenges of data collection in general, this may require additional resources. The transferability of these measures should also be considered in relation to what already exists or is standard in health systems data, and what is used in current research and health practice. A review of the current measures that are used in health systems would be helpful before final decisions are reached. In addition, data collection may need to be incentivised and built into current practice.

### Process and engagement data collection

Data will also be collected on the extent to which organisations are engaging with the uptake of the nine strategies. The Framework aims to use the current structures in place, if these are sufficient, and includes measures of the extent to which the community is working together to bring the suicide prevention activities together at the local area (see Component 3). Data from the Integrated Mapping Atlas for NSW (see Box 4) might be valuable in this context. One consideration is that data should be collected once but used often. The Framework is also not about building new structures for integration, but aims to use the current structures in place, if these are sufficient.

### Component 3: Engaging local communities, such as health services, schools, community agencies, worksites, rural and remote services, and the police, in suicide prevention

*Engagement with local communities is critical to the Framework's success. Best implementation models and sector knowledge need to be harnessed.*

An ambitious program in suicide prevention requires that the local community embraces the systems approach. In other words, an engagement and implementation strategy is required to involve people in the strategy. The present Framework recognises that communities have different levels of readiness and appetite for involvement.

The Suicide Prevention Framework for NSW supports a community engagement and development model that will form part of a regional implementation plan. This involves engagement at the level of state governments, with local councils, NGOs, hospital and health services, police, ambulance workers, housing, employment, sporting clubs, schools, consumer and family groups. It requires a strategy to align community and government organisations to determine who can deliver on which strategy and how. A key element, and perhaps the most difficult to achieve, is effective integration between services and government agencies such that support on the ground is seamless. This is crucial in ensuring that services and continuing support are available for people at risk of suicide and that they do not slip through the cracks.

The following are key considerations in planning the engagement/implementation strategy and potential approaches that might facilitate engagement and uptake. Different engagement approaches are needed for community compared to the health system.

1. Community readiness is a key feature of the Framework, in order to get buy in (Box 1).
2. Social impact research/modes may be incorporated into the plan, with collective impact a model that has been used with NGOs (Box 2).
3. Models of knowledge translation and knowledge to action are useful (Box 3).
4. Effective implementation of the Framework requires that organisations be aligned and offer integrated care. It will be helpful to map suicide prevention and other health services using geospatial techniques (Box 4).
5. Cultural diversity should be considered and engagement must be respectful and in the context of generating partnerships (for example, principles for engagement with Aboriginal communities are presented in Box 5).

## Box 1: Community readiness

Community readiness refers to the idea that a community is ready to accept that there is a problem and that something needs to be done about it. Key considerations related to community readiness are:

- The degree of a community's readiness or willingness to accept and support a program.
- As values and norms about suicide are distributed unevenly throughout a community, local leaders and professionals (i.e. gatekeepers) can help assess community readiness.
- Prevention program effectiveness is greatly influenced by acceptance levels of key members of the community.

Examples of key questions for community leaders for assessing community readiness:

- What types of suicide prevention programs/activities have occurred in your community?
  - How long have they been operating?
  - Who are they for?
  - Do they need to expand these services? If no, why not?
  - Are there plans to expand? If yes, what plans?
  - How well-received are programs by your community?
- What is the general attitude to suicide in your community?
  - Does the community see suicide as a problem?
  - Would or does the community support a prevention plan? If yes, how?
  - Are community leaders involved in prevention efforts? (list)
  - What community organisations have a focus on prevention?
- Is there information available on local suicide rates? If yes, from whom?
- How is that information made known?
- Who provides funding for these programs and how long will funding continue?
- What is the community's attitude/belief about funding prevention programs?
- Is the community aware of the costs of running a prevention program?
- Is the community aware of any local proposals that address suicide prevention? Are any funded or awaiting funding?
- What are the main barriers to prevention efforts in the community?
- What is the next step the community needs to take in the area of prevention?<sup>33</sup>

## Box 2: Collective impact

Collective impact is a way of working to facilitate and achieve large scale social change. It is a structured and disciplined approach to bringing cross-sector organisations together to focus on a common agenda to bring about long lasting change, change that cannot happen when sectors work as silos. Successful collective impact initiatives have five conditions that lead to powerful results:

1. **A common agenda for change** including a shared understanding of the problem and a joint approach to solving it through agreed upon actions.
2. **Collecting data and measuring results consistently** across all the participants.
3. A plan of action that outlines and coordinates **mutually reinforcing activities** for each participant.
4. **Open and continuous communication** across the many players to build trust, assure mutual objectives and create common motivation.
5. **A backbone organisation** with staff and a specific set of skills to serve the entire initiative and coordinate participating agencies.

The collective impact approach has shown great impact globally, addressing a range of intractable social problems, including those arising in education, physical health and environmental issues. The greatest change is seen in initiatives where community, business *and* government sectors are engaged. As such, the collective impact approach, which is strongly aligned with the systems approach principles, has potential to make a difference to suicide prevention in Australia<sup>34</sup>.

### Box 3: Knowledge transfer

Knowledge transfer is the process of taking the Framework and putting it into practice. Ten key components are needed:

1. **Establish evidence of an identified need:** Collect data to demonstrate why there is need for a new program or strategy.
2. **Evidence of research quality:** ensure that the program is underpinned by a strong evidence base.
3. **Evidence of real world effectiveness:** the evidence-base should be used to inform leadership decisions about which strategies to adopt.
4. **Leadership buy-in and support from key stakeholders:** this ensures that programs are championed and commissioned by individuals in a position to make change.
5. **Funding or other institutional support:** this is necessary to allow a program the time to develop the program or strategy in line with best evidence, a protracted period to become implemented and modified, and for the longevity or sustainability of the program.
6. **Collaboration with credible sponsors:** to allow key stakeholders to be involved at the development stage. This preferably includes collaborations across sectors or organisations to promote innovation.
7. **Provision of incentives or development of policies:** to help make the program widely known. It is also important that the new program fits within the structure of the organisation so that it is easily adopted and straightforward. Having clear guidelines and trainings for adopters is crucial.
8. **Peer networks supportive of adoption:** Individuals learn about new practices from their peers, making such networks highly impactful. Peers champion a new idea and support each other in the adoption process.
9. **Dissemination of materials:** marketing and promoting ideas (e.g. step-by-step toolkits or guidelines) can facilitate the process of education and uptake.
10. **The expectation of a cultural shift:** Achieving this goal will take time, but a cultural shift is key to program sustainability. Awareness of, and preparation for, resistance can help leaders be flexible in meeting the needs of their organisation while supporting those responsible for implementing the new program<sup>35</sup>.

#### Box 4: Integrated Mapping Atlas for NSW

The Mapping Atlas for NSW will be a very useful tool for suicide prevention. The Atlas itself aims to help consumers and providers to navigate the system by improving knowledge about available local services. Using the Atlas will help to get a global picture of all services and how they can be linked up to provide the type of care required for suicide prevention activities. This approach maps the landscape and offers oversight over range of organisations, and can then identify gaps in services. Currently the mapping identifies potential organisations, but is not yet able to reveal the types of activities relevant to suicide prevention that are undertaken within these services. Additional analysis is required.

The Atlas uses a standard classification system, the *Description and Evaluation of Services and Directories in Europe for long-term care* model (DESDE-LTC), to map the services in NSW. The use of a common language allows the pattern of mental health care provided in NSW with regions in Europe.

The Atlas concept is aligned fully with the Suicide Prevention Framework for NSW in that it is systematic, leads to integrated care across health, community managed, housing and other sectors and in that it uses a geospatial mapping approach. Issues to examine include the size and nature of the local area within the Atlas and whether these can be aligned with the local regions where the systems approach to suicide prevention will be implemented<sup>36</sup>.

#### Box 5: Principles for engagement with Aboriginal communities

1. Give due consideration to Aboriginal culture and history.
2. Establish of strong and mutually beneficial relationships.
3. Ensure programs and services are empowering for Aboriginal people.
4. Ensure services and programs engage holistically with individuals, families and communities.
5. Respect and acknowledge diversity in communities.
6. Take time<sup>37</sup>.

#### Industry buy-in and lived experience

The involvement of local banks, major companies and businesses is critically important in order to assist with local, co-ordinated framework. It allows community leaders to offer support and potentially to offer in-kind and direct funding. Lack of buy-in from lived experience and/or community leaders will have a raft of negative effects, such as more opportunity for early criticism, leading to the threat of stakeholders dropping out. Locating and engaging people with lived experience who can contribute to advocacy and to the implementation of the Framework is critical to the success of suicide prevention.

An important aspect of community engagement should be identifying what resources, programs and services are already available within localised areas (Box 6). By doing so, it is possible to evaluate and re-structure existing programs in line with best evidence practice, and to implement new, complimentary activities or programs through these services. Examples of current initiatives which align with the strategy include national and state-based crisis lines (e.g. Lifeline), assertive outreach through models such as beyondblue's *The Way Back Support Service*, suicide training for first responders and for GPs and gatekeeper training in work forces. It is also important to align with other targets such as those of COAG's 'Closing the Gap' and other initiatives.

## Box 6: Auditing local communities and health systems

Suicide Prevention Australia is collecting National survey data for development of database on suicide prevention. Data collected includes information on (1) *organisation type* (e.g., private, not-for-profit or community, social enterprise, government or other), (2) *target groups*, (3) *type(s) of services provided* (incl. direct services, i.e., provided directly to people impacted by suicide and/or related issues and indirect services, i.e., provided to people working in suicide prevention, including training, crisis support services, prevention services, postvention), (4) *type of activities* (e.g., clinical assessment and/or interventions, support groups, counselling, physical assistance, education and training, advocacy, protocols and guidelines/policies, awareness material), (5) *settings* (e.g., clinical, hospital, emergency department, residential facility, community, school, tertiary education, workplace, online), and (6) *type of delivery of intervention* (face-to-face, telephone, online, not direct, mail, pamphlet).

The Framework requires that organisations are aligned, motivated and that they understand and want to participate in shared roles and integrated services. While this is the key challenge, there are a number of potential forces that make this the right time to attempt to do this in NSW. The Framework proposes a clear suicide prevention strategy (Component 1) and knowledge (see Box 1-3) that will help develop implementation plans. The current mapping work will help identify organisations at a local area (see Box 4), and the work currently being undertaken by Suicide Prevention Australia will provide information on the roles of the many NGOs that offer services in these areas (Box 6). The work led by beyondblue will be useful in developing a community development program informed by the models outlined in this document. Meanwhile, currently in NSW, there is work undertaken by the NSW Ministry of Health to streamline relationships with NGO organisations and the Partnerships In Health may provide a focus to shift and align NGO organisations<sup>38</sup>. In addition, the Black Dog Institute is currently scoping the training needs and resources required for each of the nine strategies, as per its contract with the NSW Mental Health Commission.

As a key component of the Framework is the integration of key agencies, there will need to be preliminary work to determine how organisations communicate with each other specifically about people at risk. Currently, there may be new protocols needed to share between police, juvenile justice systems, health and NGO system.

## Component 4: Establish good implementation, governance, resources and processes at central and local areas

*Both centralised and local governance arrangements are required. Local governance structures will be necessary to provide leadership in the planning, implementation and evaluation of local suicide prevention action plans. Central governance will be responsible for resourcing and monitoring local suicide prevention teams to implement the Framework, separate agencies managing central evaluation, guiding quality frameworks and providing training.*

### Governance

Suicide prevention involves multiple stakeholders and different systems to integrate in a way not yet seen in NSW. Multi-governance structures will be required for successful realisation of the objectives stated within the Framework. At the local level, multiagency suicide prevention teams must be established with responsibility for leading, planning, implementing, evaluating and maintaining the systems approach within their respective communities. These multiagency groups might be built around Primary Health Networks, Local Health Districts, Local Councils or hospitals, for example. The overarching structure will vary between local communities and be entirely dependent on existing local resources and organisational capacity. However the key similarity across all multiagency suicide prevention groups will be the range of partners from across primary care, community

managed organisations, local health districts, emergency services, peak bodies, schools, local councils, and those with lived experience, that will come together to form the multiagency group.

The multiagency suicide prevention group would operate autonomously in the planning, development, implementation and evaluation of their local action plan. They would have responsibility for allocation of local resources, ensuring the Framework is sustained for the future as well as achieving the needs of the present.

The multiagency groups would be resourced and supported centrally, via the NSW Ministry of Health. Central governance is necessary to provide a coordinated and integrated approach in the delivery of the Framework at the state-wide level. As such, consideration must be given to the establishment of a permanent suicide prevention resource within the NSW Ministry of Health, which has a coordinating role, which stays in place over time with changes in State Government, and negotiates with Commonwealth Government to align state-led suicide prevention programs.

The central governing structure would be responsible for monitoring and resourcing suicide prevention teams at the local level to implement the Framework, and support and coordinate other external agencies to manage the centralised evaluation, develop quality assurance frameworks and provide training and support for each of the nine strategies. This resource would also convene and support dedicated expert strategy knowledge groups to support implementation.

A proposed governance framework is shown in Figure 5. The following functions are required at local, national / state body and state government, levels.

### Local level

- An audit of data about suicides and suicide attempts that have occurred locally to better understand local factors, such as high risk groups.
- An audit of local services and organisations to identify gaps and to recognise strengths (e.g. what we have and how we can use it to address the gaps), with sensitivities for any privacy concerns (e.g. in schools).
- Local suicide prevention action plan:
  - The Framework determines local level action regarding need for suicide prevention training and materials, and the structural/legal requirements related to implementation of suicide prevention strategies included in the systems approach. For example, suicide prevention training includes gatekeeper training, front-line staff (police, ambulance), GPs, school based peer support, and media education. Local leaders in local areas may include local councils, especially in rural and remote areas.
- Establishment of a multi-agency suicide prevention group:
  - Considering local organisational capacity in the community.
  - In general, key local leaders would include:
    - Primary health networks
    - Health professionals and hospitals
    - Police
    - NGO sector, e.g., Lifeline
    - Local councils (existing youth centres, Aboriginal organisations)
    - School leaders
    - People with lived experience of suicide
    - Dependent on locality (e.g., farmers in local populations; LGBTI people in certain postcodes) and inclusive of local at risk populations
  - Including the involvement of industry, with industry leaders involved. These local committees could be seen as private/public partnerships – with strong industry leadership that would create sustainability and credibility, and which might bring strong business skills and involvements together.
- Local level evaluation.



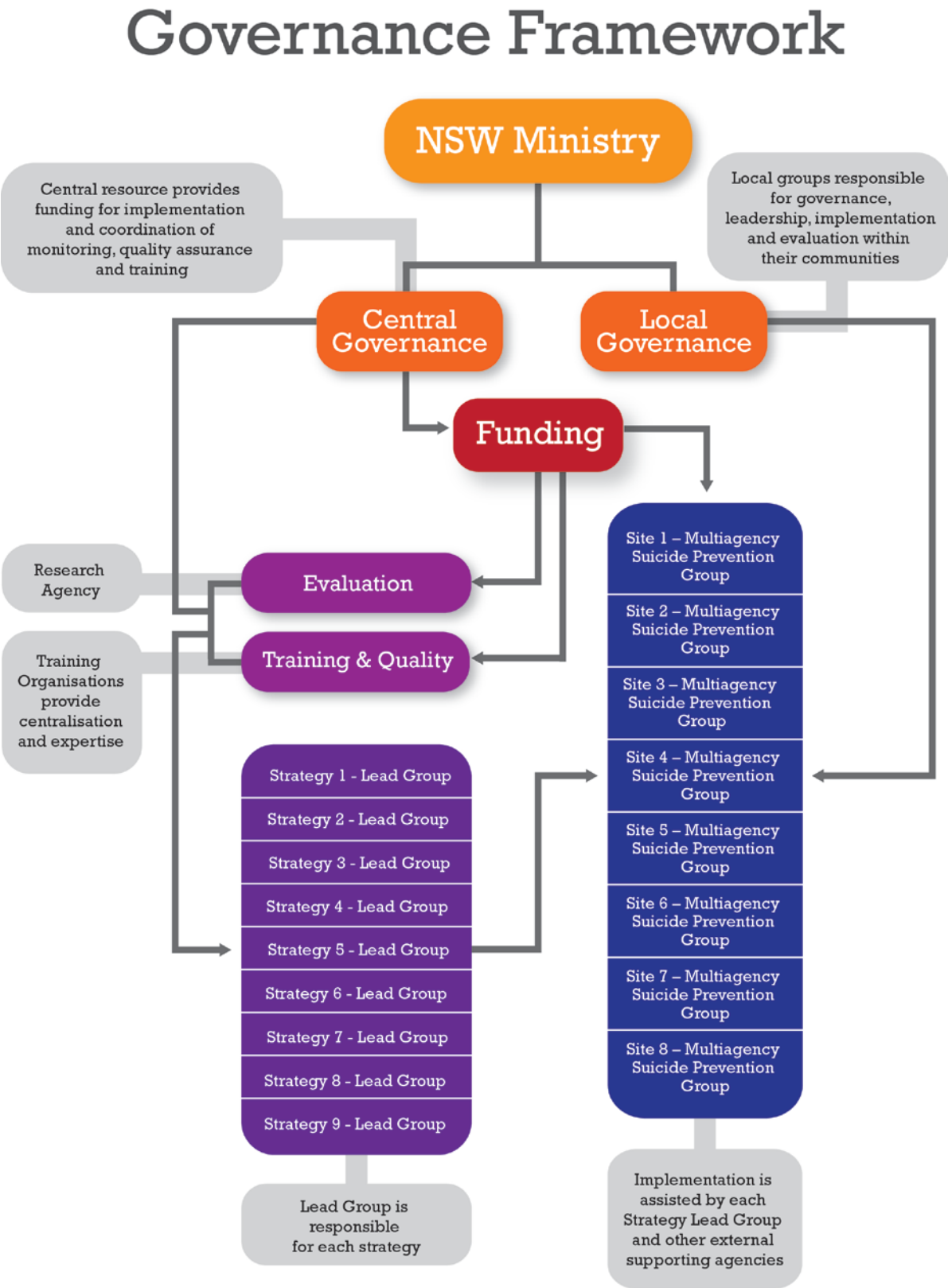
## National or state body level

- Oversight of engagement and implementation:
  - Integration with current initiatives in government (e.g. models of integrative care).
  - Linking all state/federal bodies.
  - Providing broad assistance:
    - Actions might include establishing a central repository to track research on suicide prevention in NSW. Funding agencies and the staff who implement suicide prevention programs would also benefit from a centralised way to stay abreast of new research being conducted within and outside NSW.
    - Provide dissemination materials and technical assistance to help organisations implement new approaches or adapt existing ones.
- Education, training and evaluation:
  - Develop strategy level lead groups to guide and inform implementation of each strategy.
  - Undertake an overarching evaluation strategy where:
    - Data on outcome measures and healthcare services are acquired, mapped and spatially analysed.
    - Data collection and analysis of trends in suicide deaths and attempts in NSW are tracked on an ongoing basis to monitor progress towards achieving the objectives of the Framework. Trends in suicide data will be reported through the annual suicide trends publications.
  - Support local level prevention teams to undertake local common data collection, including training and support for use of measures, management and analysis.
- Develop a quality framework:
  - Those responsible for program implementation should be involved in training peers to implement new approaches and use new technologies.
  - Develop a handbook and accompanying plain English resources on knowledge translation, outlining how communities can put together the proposed program.

## NSW Government level

- Central governance.
- Supporting the development of a centralised suicide surveillance system and facilitating access to linked data sources.
- Monitoring outcomes (measures and the reporting process e.g., via a central portal) allowing local multiagency suicide prevention teams to track their performance with respect to the actions or strategies they are involved in, and providing the basis for modifying actions to improve their effectiveness. Monitoring will require improvements in the use, efficiency and scope of coronial, hospital admission, emergency department and ambulance NSW data collection and reporting.
- Convening regular meetings with local multiagency suicide prevention groups and external supporting agencies to discuss progress on the implementation of the Framework, ensure that policies and programmes are consistent and mutually supportive, and decide what new initiatives should be implemented.
- Linking with national and other state strategies and frameworks.
- Ensuring suicide prevention activities are aligned with other initiatives within government such as electronic health records, demonstration projects, integrative care committees for Aboriginal health or refugee health.

Figure 5. Governance framework for implementation of the systems approach to suicide prevention



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Aboriginal Affairs  
Ambulance NSW  
Australian Women's Health Network  
BDI Health  
Beyondblue  
Corrective Services  
CRESP Consumer Committee  
Department of Education and Communities  
Department of Premier and Cabinet  
Department of Family and Community Services  
Juvenile Justice NSW  
Lifeline Australia  
Lifeline Hunter/Central Coast  
MATES in Construction Aus Ltd  
Mental Health Drug & Alcohol Office, NSW Ministry of Health  
Mental Health at Work  
National StandBy Response Service  
Newcastle Mental Health Service  
Newcastle Police, Waratah Police Station  
NSW Health Pathology/Newcastle Forensic Medicine Branch  
NSW Mental Health Commission  
NSW Police  
NSW Transport  
Office of Local Government  
On the Line  
ReachOut Australia  
State Coroner NSW  
St Vincent's Hospital  
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